DOCUMENT RESUME

ED 283 318 EC 192 747

| | |
|---|---|
| AUTHOR | Levine, Michael P. |
| TITLE | How Schools Can Help Combat Student Eating Disorders. Anorexia Nervosa and Bulimia. |
| INSTITUTION | National Education Association, Washington, D.C. |
| REPORT NO | ISBN-0-8106-3289-6 |
| PUB DATE | 87 |
| NOTE | 279p. |
| AVAILABLE FROM | NEA Professional Library, P.O. Box 509, West Haven, CT 06516 ($22.50 hard copy, ISBN-0-8106-3290-X, Stock No. 3290-X; $11.95 paperback, Stock No. 3289-6). |
| PUB TYPE | Information Analyses (070) -- Reports - Research/Technical (143) -- Reports - Descriptive (141) |
| EDRS PRICE | MF01 Plus Postage. PC Not Available from EDRS. |
| DESCRIPTORS | Adolescents; *Anorexia Nervosa; *Body Image; Body Weight; *Bulimia; Case Studies; *Eating Habits; *Emotional Disturbances; Females; Health Education; High Schools; Nutrition; *School Role; Self Esteem; Social Values; Teacher Role |

ABSTRACT

This book presents a comprehensive review of anorexia nervosa and bulimia and the roles that schools can have in preventing, identifying, and treating these disorders. Chapter 1 provides an overview of student eating disorders and presents a case study of a high school student with an eating disorder. Chapter 2 discusses the nature of anorexia nervosa, including major and commonly associated characteristics, the effects of starvation, and teaching implications. Chapter 3 presents a case history of a high school student with anorexia nervosa, from both the student's and her parents' perspectives. Chapter 4 considers the nature of bulimia, including major and commonly associated characteristics, the difference between anorexia nervosa and bulimia, and teaching implications. Chapter 5 presents a case history of a high school student with bulimia, from both the student's and her parents' perspectives. The extent of eating disorders in high school students is addressed in Chapter 6, and the role of culture in the cause of eating disorders is discussed in Chapter 7. Chapters 8 and 9 discuss the causes of anorexia nervosa and bulimia, respectively. Chapter 10 addresses the role of school employees in the prevention of eating disorders. Most chapters provide a list of references. Appendices list four eating disorders organizations and suggested readings and films, including materials for students as well as teachers. (CB)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED283318

7776

How Schools Can Help Combat

# Student Eating Disorders:

## Anorexia Nervosa and Bulimia

*by Michael P. Levine*

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
National Education Association
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC 192747

A National Education Association Publication

2

How Schools Can Help Combat

# Student Eating Disorders:

## Anorexia Nervosa and Bulimia

*by Michael P. Levine*

*Introduction by David M. Garner*

nea PROFESSIONAL LIBRARY

National Education Association
Washington, D.C.

To
Mary, Seth, Corey, and Zeva

Copyright © 1987
National Education Association of the United States

**Note**

The opinions expressed in this publication should not be construed as representing the policy or position of the National Education Association. Materials published as part of the NEA Combat Series are intended to be discussion documents for teachers who are concerned with specialized interests of the profession.

**Library of Congress Cataloging-in-Publication Data**

Levine, Michael P.
How schools can help combat student eating disorders.

(How schools can help combat series)
Bibliography: p.
1. Eating disorders in children. 2. Students—Counseling of. I. Title. II. Series.
RJ506.E18L48 1987 618.92'852 86-16424
ISBN 0-8106-3289-6 (pbk.)
ISBN 0-8106-3290-X

**The Consultants**

Donna Hooker Allen, recovered bulimic, Rutland, Vermont

Andrea Bull-McDonough, Coordinator, Eating Disorders Prevention Program for Anorexia, Bulimia, Care, Inc., Boston, Massachusetts

Amy Baker Enright, Executive Director, The Bridge Foundation (Center for the Treatment of Eating Disorders and National Anorexic Aid Society), Columbus, Ohio

Marilyn Frankfurt, Senior Clinician, Yale Eating Disorders Clinic, New Haven, Connecticut

Mary Jane Gandour, doctoral candidate and former high school teacher, Purdue University, West Lafayette, Indiana

David M. Garner, Professor of Psychiatry, University of Toronto; and Director of Research, Department of Psychiatry, Toronto General Hospital, Ontario

Renee Long, Community Nutritionist and WIC Dietitian, Knox County Health Department, Mt. Vernon, Ohio

Karen L. Maddi, Research Associate, Eating Disorders Program, Northwestern Memorial Hospital, Chicago, Illinois

Dennis A. Marikis, Director of Mt. Vernon Psychological Services, Mt. Vernon, Ohio

Yvonne Martini, Associate Director, American Anorexia/Bulimia Association, Inc., Teaneck, New Jersey

Estelle Binn Miller, founder, First Vice President, and Executive Director, American Anorexia/Bulimia Association, Inc., Teaneck, New Jersey

Katherine O. Oldis, Special Teacher of Reading, Foxcroft Academy, Dover-Foxcroft, Maine; and mother of bulimic nervosa daughter

Jean Rubel, President, Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED), and Eating Disorders Specialist, Sacred Heart General Hospital, Eugene, Oregon

Tracy W. Schermer, M.D., Director, Kenyon College Health and Counseling Center; and college physician and team physician, Gambier, Ohio

Janet L. Sonne, Clinical Instructor and Staff Psychologist, Eating Disorders Treatment Program, Loma Linda University Medical Center, California

**The Advisory Panel**

Sheri Bauman, Counselor, Centennial Adult High School, Ft. Collins, Colorado

Patrick J. Carr, High School Media Specialist, Tuba City, Arizona

Sue Chaffin, Certified Counselor, Ithaca High School, Michigan

Gary Delvin, Elementary Principal, Lebanon, Ohio

Dana T. Elmore, Professor, Teacher Education Division, San Jose State University, California

Lesa D. Esbaum, Student Director, NEA Board of Directors

Pat Jenkins, Middle School Counselor, Bardstown, Kentucky

Robert Edward Johnson, Professor of Education, University of North Alabama, Florence

Eugene A. Kroschel, School Social Worker, New Trier High School, Winnetka, Illinois

Thomas McKibben, Special Education teacher, Ashford High School, Alabama

Pam Newman, Special Education Consultant, Western Hills Area Education Agency, Sioux City, Iowa

Catherine Pedretty, Director of Guidance, Dunedin High School, Florida

Pamela B. Rogers, School Psychologist, Norwood Public Schools, Massachusetts

Connie Ryan, Librarian, Liberty Union High School, Baltimore, Ohio

Denis P. Sicchitano, School Counselor, South Middleton School District, Boiling Springs, Pennsylvania

# CONTENTS


Introduction by David M. Garner ..... 11

Preface ..... 17

Chapter 1:
Overview of Student Eating Disorders ..... 19
Karen ..... 19
What Is an Eating Disorder? ..... 23
What Are the Eating Disorders? ..... 24
Should School Staff Be Concerned
About Student Eating Disorders? ..... 26
The Goal and Guiding Principles of This Book ..... 28

Chapter 2:
Anorexia Nervosa ..... 37
General Definition ..... 37
Natural History ..... 39
Major Characteristics ..... 40
The Effects of Starvation ..... 45
Commonly Associated Characteristics ..... 48
Anorexia Nervosa with Bulimic Complications ..... 50
Anorexia Nervosa Versus
Other Psychological Disorders ..... 51
The Effects of Anorexia Nervosa ..... 53
Teaching About Anorexia Nervosa:
Conclusions and Implications ..... 57

Chapter 3:
Vicki's Story: The Personal Side of Anorexia Nervosa .... 62
The Adolescent ..... 62
The Parents ..... 70

Chapter 4:
Bulimia ..... 82
General Definition ..... 82
Terminology ..... 83
Natural History ..... 84
Central Features ..... 86
Commonly Associated Characteristics ..... 93
Pigging Out ..... 95
Is Bulimia an Addiction to Food? ..... 96

What Is the Difference Between Anorexia Nervosa and Bulimia? ..... 98
Teaching About Bulimia: Conclusions and Implications ..... 98

Chapter 5:
Amy's Story: The Personal Side of Bulimia ..... 105
The Adolescent ..... 105
The Parents ..... 114

Chapter 6:
The Extent of Eating Disorders in High School Students . 124
Epidemiology ..... 125
Anorexia Nervosa ..... 126
Bulimia ..... 130
Conclusions and Implications ..... 140

Chapter 7:
The Role of Culture in the Cause of Eating Disorders ..... 146
Boundaries of a Cultural Model ..... 147
The Glorification of Thinness ..... 149
The Pursuit of Thinness ..... 153
The Relentless Pursuit of Thinness ..... 161
Eating Disorders and the Psychology of Women ..... 163
History, Culture, and Psychopathology ..... 169
Conclusions and Implications ..... 170

Chapter 8:
The Causes of Anorexia Nervosa: A Multidimensional Perspective ..... 178
The Three P's ..... 178
Biological Predispositions ..... 179
Predisposition: The Individual Within the Family ..... 181
Individual Psychological Predispositions ..... 188
Precipitants ..... 193
Perpetuators ..... 197
A Multidimensional Model ..... 201
Conclusions and Implications ..... 203

Chapter 9:
The Causes of Bulimia: A Multidimensional Perspective . 211
Biogenetic Predispositions ..... 211
Familial Predispositions ..... 213
Individual Predispositions: Johnson's Affect Regulation Theory ..... 217
Precipitants ..... 219
Perpetuators ..... 226

The Vicious Circle ..... 231
Conclusions and Implications..... 235

Chapter 10:
The Role of School Employees
in the Prevention of Eating Disorders..... 242
The Teacher as Educator in the Classroom ..... 243
The Teacher as Adviser ..... 252
The Teacher in the Community..... 262
Conclusions and Implications..... 263

Appendices..... 269
I. Eating Disorders Organizations..... 271
II. Suggested Readings and Films..... 274

# Introduction

by David M. Garner, Professor of
Psychiatry, University of Toronto

The recent surge in professional and public concern about eating disorders has led to the appearance of innumerable books on the topic. Although some of these have served a useful purpose, the sheer number ensures that many are redundant. In addition to books for professionals, there has been an abundance of personal accounts that have been overly simplistic and, as I will mention later, that indirectly may have had deleterious effects. The social significance of the widespread fascination with these disorders leading to the array of publications is an interesting area for sociological speculation in its own right. Moreover, it certainly raises the standard of expectations for any new contribution. In light of this admonition, Dr. Levine must be congratulated for writing what I believe to be the best book that I have seen to date aimed at those who may not be familiar with the disorders of anorexia nervosa and bulimia (the latter term will be known increasingly as *bulimia nervosa*). It is an honor and a sincere pleasure to be able to provide a few introductory remarks for this volume.

There has been much confusion in the definition of anorexia nervosa and related disorders. Simply cataloging the terms that have been applied to the "binge-eating" syndrome is a significant undertaking. In addition to the more accepted terms *bulimia* and *bulimia nervosa*, other synonyms have entered the psychiatric nomenclature, including *dietary chaos syndrome*, *bulimarexia*, *normal-weight bulimia*, and *the abnormal normal-weight syndrome*, among others. The use of the term "bulimia" has resulted in some confusion since the same word has been used to describe both a relatively common

symptom, which may not necessarily imply psychopathology, and a serious psychiatric syndrome. After considerable debate, it appears bulimia nervosa will become the accepted term. Dr. Levine not only defines these eating disorders in a clear way, but he also recognizes the close association between anorexia nervosa and bulimia nervosa. This is extremely important since some have assumed that even though both disorders share a common psychopathology, they must be very different because of their weight status. It must be remembered that, although bulimia nervosa patients are at a statistically normal weight, their disorder has, in virtually all cases, been precipitated by extreme dieting and weight loss. In fact, evidence from several studies indicates that many bulimia nervosa patients have lost as much weight as patients with anorexia nervosa; the only difference is that the bulimic patient has started at a much higher weight level (3).* According to "set point" theory, these so-called "normal weight bulimics" may be just as unrealistic in their pursuit of a statistically normal weight as is the anorexic in striving for emaciation. This factor has many practical ramifications for treatment (4).

Dr. Levine repeatedly emphasizes the multidimensional nature of the eating disorders. There is a growing consensus that both anorexia nervosa and bulimia nervosa are final common pathways with multiple routes of entry. Dr. Levine is careful to dispel the "uniformity myth" by such statements as "Not all anorexics correspond to the stereotype of the perfectionistic, compliant, and sexually naive adolescent" (p. 51). Although this view of these disorders as multidetermined has gained acceptance, still there are some who primarily attribute the disorders to one factor such as depression, stress, anxiety, lack of assertiveness, or poor labeling of emotional states. Particularly in the case of bulimia nervosa, the latter view may reflect confusion

*Numbers in parentheses appearing in the text refer to the References at the end of each chapter.

between precipitants and fundamental causes. Although it is true that most bulimia nervosa patients are stressed, anxious, nonassertive, and depressed, binge-eating is rarely seen in individuals who do not diet and/or maintain what Russell (9) has referred to as a suboptimal weight. Despite our greatly improved understanding of the etiology of bulimia nervosa and the tremendous advancements in treatment (see Garner and Garfinkel [7] for a review), it is important to emphasize that our understanding is far from complete. For example, we do not understand why some individuals are able to successfully suppress their weight but fail to develop the pattern of binge-eating. We do not understand the action of various drugs (including those that are pharmacologically unrelated) that have been found to be effective in a minority of bulimia nervosa cases. Despite ample evidence that most cases of anorexia nervosa have a psychological origin, we do not understand the reasons for the remarkably high concordance rates among monozygotic compared with dizygotic twins. We do not understand the pathophysiology of starvation and how exercise may potentiate dietary restriction. And these would appear to be the easier questions to answer! The precise influence of psychological, familial, and cultural factors is undoubtedly more complex. Nevertheless, we have come a long way in the last decade, and many have benefited from the treatment recommendations that have been derived from our improved understanding of etiology.

Today few would challenge the argument that the current cultural preoccupation with slenderness in women has played a fundamental role in the increased incidence of eating disorders. Only in the last decade, however, has the importance of sociocultural factors been recognized in the development of anorexia nervosa. It was with some apprehension that Paul Garfinkel and I presented our original findings that used *Playboy* centerfolds and Miss America Pageant contestants to document the shift toward an ever thinner standard of attractive-

ness for women that was then linked to the rise in eating disorders (8). We also provided data from studies with ballet dancers which indicated that exaggerated emphasis on slenderness, particularly within a competitive environment, was a risk factor for anorexia nervosa (5, 6). Although these findings confirmed the clinical speculations of Bruch (1) and others, we were concerned that the "cultural hypothesis" might be interpreted as a dismissal of the individual psychopathology in the etiology of the disorder. Indeed there have been some who have attributed eating disorders almost exclusively to culture without apparent appreciation for the fact that, in the precise sense, culture can rarely "cause" serious psychological disturbance without mediation from the individual and the family. One of the most laudable aspects of Dr. Levine's presentation of the topic of "cultural influences" in this publication is the balance he has achieved between individual and societal contributors to disturbed eating patterns. Moreover, he has gone beyond simply describing the cultural influences and has provided educators with a series of practical recommendations for helping the individual to deemphasize slenderness as the model of physical attractiveness and to decouple body shape from self-esteem and self-acceptance. He conveys the spirit of pesonal liberation that comes from the recognition that self-esteem need not be tied to unrealistic social expectations. It very well may be that this type of approach can moderate the continued spread of eating disorders.

On the point of prevention, however, a word of caution is in order. It has become clear to many professionals and nonprofessionals alike that prevention of eating disorders would be enormously cost effective in both human and economic terms. Prevention efforts are currently under way by many organizations. These consist of the distribution of information on eating disorders, lectures at schools, announcements on radio and television, just to mention a few. While these efforts are probably beneficial in many instances, they may also be harmful in

some cases. As has been argued elsewhere (3), care must be taken not to unwittingly glamorize eating disorders. In a steady stream of popular novels, television dramas, and "confessions" of certain media personalities, eating disorders have acquired a not-altogether-unfavorable stereotype. They have apparently captured the fascination of the public by their association with attributes such as ultrathinness, intelligence, upper-class status, perfectionism, and physical fitness. This phenomenon has led some individuals to actively pursue the development of anorexia nervosa and bulimia nervosa as ways to express their suffering or their quest for identity. Bruch (2) has referred to these sad victims of social contagion as "me too anorexics," and she has asserted that they are clearly different from those who acquired the disorder in previous decades. In our well-intentioned efforts to prevent eating disorders, then, we could inadvertently make them appealing to adolescents who are psychologically vulnerable. This statement should not be construed as an indictment of prevention efforts but only as a caution that justifies conducting careful research to determine the effects of prevention initiatives. On the topic of prevention, Dr. Levine presents a balanced view that is hopeful yet circumspect.

Probably the most outstanding characteristic of this book is the remarkable skill that the author has shown in synthesizing a vast and complex field. He treats the subject matter with depth and scientific accuracy, and at the same time is able to convey current understanding in a practical and readable way. He captures the phenomenology of these disorders and leaves the reader with realistic hope and useful tools for changing the attitudes that have led to the proliferation of eating disorders since the 1960s.

## References


1. Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge, Mass.: Harvard University Press, 1978.
2. _____. "Four Decades of Eating Disorders." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel. New York: Guilford Press, 1986.
3. Garner, D. M. "Iatrogenesis in Anorexia Nervosa and Bulimia Nervosa." *International Journal of Eating Disorders* 4 (1985): 701–726.
4. _____. "Cognitive Therapy for Bulimia." *Annals of Adolescent Psychiatry* 13 (1986): 358–90.
5. Garner, D. M., and Garfinkel, P. E. "Sociocultural Factors in Anorexia Nervosa." *Lancet* 2 (1978): 264.
6. _____. "Sociocultural Factors in the Development of Anorexia Nervosa." *Psychological Medicine* 10 (1980): 649–56.
7. _____, eds. *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*. New York: Guilford Press, 1985.
8. Garner, D. M.; Garfinkel, P. E.; Schwartz, D. M.; and Thompson, M. M. "Cultural Expectations of Thinness in Women." *Psychological Reports* 11 (1980): 483–91.
9. Russell, G. F. M. "Bulimia Nervosa: An Ominous Variant of Anorexia Nervosa?" *Psychological Medicine* 9 (1979): 429–48.

# Preface

This book grew out of a series of articles written by several colleagues and me for *The Kenyon College Alumni Bulletin* (Winter 1985). Ironically, I was reluctant to contribute to that publication, because I felt there would be little general interest in anorexia nervosa and bulimia. I could not have been more wrong. Eating disorders seem to be everywhere (see Chapter 6), and the response from parents, students, alumni, teachers, and school librarians was overwhelming. This reaction, coupled with my other efforts in preventive education, has convinced me that sound knowledge and authoritative guidance can help prevent eating disorders and contribute to the education—in the true sense of the word—of all students.

This book reflects the assistance and support of many individuals. I am especially grateful to Amy Enright and Colleen Tootell of the National Anorexic Aid Society and the Center for the Treatment of Eating Disorders in Columbus, Ohio, for arranging the interviews presented in Chapters 3 and 5, for providing me with newsletters and other "inside" information, and for their continuing encouragement of my efforts in preventive education. In this same vein Norma Fladen, Executive Director of the Knox County Mental Health Association, was instrumental in obtaining the pamphlets listed in Appendix II and in helping me see how a teacher like myself could use existing resources for public education in mental health. I am also indebted to the following people for their generosity in sending me numerous publications and works in press: Dr. David Garner, Dr. Craig Johnson, Drs. Susan and O. Wayne Wooley, and Dr. Regina Casper. I would also like to thank Mary

Suydam, Pat Bosch, and Sonja Gallagher for their assistance with transcriptions, correspondence, and computer printers. Finally, fond thanks are extended to the friends who saw me through the research and writing: Mary Suydam, Dennis Marikis, Ellen Sullins, Jay Tashiro, Linda Smolak, and Dick Hoppe.

—Michael P. Levine

**The Author**

Michael P. Levine is Associate Professor of Psychology at Kenyon College, Gambier, Ohio; the Faculty Co-Director of the Off Campus Activities Program in Psychology; and the Coordinator of Career Advising for Psychology. He is also the author of *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*, published by the National Anorexic Aid Society.

CHAPTER 1

# Overview of Student Eating Disorders

## Karen

Karen (a pseudonym) began to develop an eating disorder at the end of her sophomore year in high school. Throughout the 10th grade she was 5'2" tall and weighed approximately 95 pounds, but then, for no reason she can recall and with no intent to diet, she lost her appetite and her weight fell to 89 pounds. She enjoyed very much the attention and concern she received from her parents and the family physician. Subsequently (if not consequently), she began to severely limit her food intake. She cut out breakfast and lunch and ate only plain bagels several times a day. At times the hunger created by this semistarvation regimen became too much, and some afternoons when she was all alone she gorged herself on pizza and cookies. After such an indulgence she fasted for the remainder of that day and ate nothing but a few bagels for each of the next few days until hunger overwhelmed her once more.

Her family and friends began to question her refusal to eat at mealtimes, but these inquiries and exhortations only motivated her to cling to her diet of bagels plus a few low-calorie foods. This resolve was strengthened by the fact that, unbeknownst to her, her binge-eating was preventing her from losing weight. In her mind, other people were eating far more and losing weight, while she was "really eating only bagels" and her weight was

fluctuating between 90 and 103. She tried to eat normal meals, but this made her feel panicky because she was certain they would cause her weight and her body to balloon.

Throughout her junior and senior years in high school Karen alternated frequently between a very uneasy peace with "normal meals" and a fierce battle with her restrictive diet and its constant companion, extreme hunger. She became obsessed with her weight and with her inability to reduce below 92 pounds. Feeling like a "terrible failure," she deflected her friends' requests to go out with them, and gradually she cut herself off from them completely. Her old self-confidence gave way to a profound feeling that she was hopelessly unprepared to cope with the challenges of schoolwork, friendships, and dating.

At one point Karen tried to escape from this web of despair by making an all-out effort to lose weight. However, when she reached 89 pounds again, she became so sickly, cold, hungry, and frightened of losing control that she couldn't concentrate. As before, the constant and intense hunger would occasionally become too much, and she would binge-eat on a weekend afternoon when her parents were out of the house. Her concerned and frustrated parents took her to a psychotherapist who did not know how to help, so Karen was referred to an in-patient eating disorders clinic affiliated with a nearby university. This sequence ended in frustration for Karen and her parents because the clinic's policy was not to hospitalize individuals whose weight was as high as hers.

Things settled down somewhat during the summer following high school graduation, and Karen's weight climbed to 97 pounds. Although she was very apprehensive about leaving home, she enrolled in a college far away. As she began college life, she found she was just plain scared, and soon she started to eat voraciously for hours on end, even though she was not hungry. When her weight shot up to 107 pounds—quite acceptable for a person 5'2" tall—she became so disgusted with herself that she

implored her roommate, who occasionally induced vomiting after a meal, to teach her how to purge in this manner. Karen was determined to control her vomiting by resorting to it only after a particularly bad binge or a frightening weight gain. Nonetheless, a short time later she was throwing up automatically after every meal. Her life became focused on obtaining food, binge-eating, and throwing up.

Thanksgiving vacation was a nightmare for Karen and her parents. Social expectations and limited privacy interfered with Karen's bingeing and purging, and she became sullen, contentious, and spiteful. Karen returned to college in December, but the constant bingeing and purging began to take their toll in the form of inability to concentrate, dropped classes, weakness, severe stomach pains, sleeplessness, depression, anxiety, and a crushing sense of alienation from other people. She felt so alone because the binge-purge cycles were "consuming" her life and because no one seemed to understand. Many people told her, "Just don't eat so much and you will be all right," and one physician told her "it was just a phase you're going through." During Christmas vacation, she saw a succession of general practitioners, pediatricians, and psychologists, but her bingeing and purging continued, and her weight fluctuated between 88 and 95 pounds.

After much deliberation it was decided that Karen would return to college and stay there as long as she remained in therapy with a psychologist specializing in eating disorders and as long as she kept her weight above 90 pounds. She was delighted finally to have found someone who understood her disorder, but, nevertheless, her days became a nightmare of fasting until her roommate went to work in the early evening, and then bingeing and purging until her roommate returned from work at 9:30 P.M. Karen's weight dropped to 83 pounds, but the rewards for this accomplishment were stomachaches, chest pains, weakness, dizziness, an inability to get warm, chronic hunger, and an unassailable "feeling" that she was "too fat." In early February, simultaneously scared and relieved, she was admit-

ted by her psychologist to a private hospital with a special unit for the treatment of anorexia nervosa and bulimia.

Karen spent just over three months in this program. When she was released, she was no longer bingeing and purging, and she was able to maintain a fairly healthy body weight and a stable regimen of three meals per day. However, she was very depressed, a problem with which she continues to wrestle. She is currently seeing a therapist who specializes in the treatment of eating disorders, and this therapy focuses on Karen's depression, her confusion of developmental issues with eating and weight management, and her tendency to induce vomiting as a response to a particularly bad day.

Karen clearly suffered from a severe eating disorder. When asked, "What is an 'eating disorder'?" even most experts would be inclined to answer "anorexia nervosa and bulimia" before proceeding to define these technical terms. Although this approach is sensible, it is very important for people interested in prevention not to allow the phrase "eating disorder" to lose its more general meaning by virtue of repetition or reflexive translation (10).

Self-starvation and binge-eating tend to be awe-inspiring topics for adolescents in search of notoriety or relief from pressures of identity formation. The frequent characterization of anorexia nervosa and bulimia as the exclusive, tragic problems of talented and wealthy young girls only adds to the unfortunate glamour surrounding eating disorders (2, 5). Careful consideration of two questions—What is *an* eating disorder? and What are *the* eating disorders?—will enable school employees to highlight the seductiveness and destructiveness of anorexia nervosa and bulimia without resorting to scare tactics.

# What Is an Eating Disorder?

In psychiatry "disorder" implies the presence of abnormal patterns of behavior and thought. There is no agreed-upon definition of "abnormal," but the following criteria (3, 10, 11), represented by the acronym IMAD, are very useful in distinguishing the abnormal from the unusual or idiosyncratic:

INEFFICIENCY: Abnormal behavior disrupts the ability to fulfill obligations as a family member, student, friend, athlete, etc. It also retards psychological and social growth, and, as in younger adolescents, it may inhibit physical development.

MISERY: Although the person may vigorously deny any sort of suffering, abnormal behavior is usually accompanied by high levels of anxiety, depression, tension, guilt, and worry.

ALIENATION: Abnormal behavior reduces or eliminates completely the desire or the ability to form fulfilling relationships.

DISTURBANCE: Abnormal behavior tends to disgust, frighten, or otherwise disturb the person or others. The cause of this concern, particularly for other people, is behavior that departs significantly from accepted practices, is unpredictable and uncontrollable, or is dangerous.

Applying the IMAD criteria, an "eating disorder" can be defined as any collection of eating habits and weight management practices in which (10)—

1. The person's health and vigor are ultimately reduced, and his or her life may be threatened. (INEFFICIENCY and DISTURBANCE)
2. Isolation and secretiveness significantly reduce the ability to fulfill obligations to the self and

others. (INEFFICIENCY and ALIENATION)

3. There is suffering in the form of obsessions plus recurrent anxiety, irritability, depression, and guilt. (MISERY and INEFFICIENCY)
4. The preoccupation with food and weight control increases self-absorption and emotional instability, thereby disrupting the capacity to love and care for others and themselves. (ALIENATION and DISTURBANCE)
5. The person is out of control. This is evident in the persistence of dysfunctional eating habits and weight control practices, despite the realization of their irrationality or dangerousness, or despite the fact that others are befuddled and horrified by what seems so obviously extreme and self-destructive. (DISTURBANCE and INEFFICIENCY)

## What Are the Eating Disorders?

Eating disorders can also be defined in terms of the specific syndromes that constitute the focus of Chapters 2 and 4. These include (1, 13) the following:

- Restricting anorexia nervosa
- Anorexia nervosa with bulimic complications
- Bulimia in a person who was previously anorexic
- Bulimia in a person who has never been significantly over- or underweight (normal-weight bulimia)
- Bulimia in a person who was previously overweight ("thin-fat" people)
- Bulimia in a person who is currently overweight.

The exact relationship(s) among these categories is unclear. But, as Figure 1–1 shows, it is possible to conceptualize them along a continuum according to level of present body weight and presence of extreme caloric restriction and/or binge-

| Self-Starvation | | Binge-Eating | | |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |
| Extreme Emaciation | | Normal Weight | | Extreme Obesity |

1. Restricting anorexia nervosa
2. Bulimic anorexia nervosa
3. Normal-weight bulimia
4. Thin-fat people (formerly obese)
5. Extreme obesity

*Note*: This figure must not be interpreted to mean that all obese or formerly obese people binge-eat, only that some have a problem with binge-eating.

Figure 1–1. The Spectrum of Eating Disorders (Adapted from Vandereycken and Meerman (13, p. 4)

eating (13). This perspective acknowledges the shared features of anorexia nervosa and bulimia instead of artificially categorizing them. It also makes an important developmental point: having had one eating disorder, a person is at risk for the other.

Taken together, this spectrum and the definition of "abnormal" emphasize the necessity of blurring the distinction between anorexia nervosa and bulimia before sharpening the focus on each. It is important to recognize that eating disorders share many features, including (1, p. 109)—

1. A fear of becoming fat and a drive to become thin
2. An obsession with food, weight, calories, etc.
3. The reliance on eating and/or refusal to eat in order to cope with emotional discomfort, stressful life events, and developmental challenges
4. The fact that female sufferers outnumber males at least 9 to 1
5. An increased incidence of depression, obesity, substance abuse, and eating disorders in the families of sufferers

6. A world view that values external appearances over personal integrity.

This list illustrates an important theme of this book: eating disorders are not fundamentally disorders of eating; they are multidimensional and multidetermined disturbances in the perception and expression of one's being-in-the-world (2, 5).

## Should School Staff Be Concerned About Student Eating Disorders?

The answer to this question is a resounding "Yes!" The following statistics make it clear that anorexia nervosa and bulimia often develop during adolescence, and that eating disorders occur with alarming frequency in middle school and high school students (see Chapter 6 for a detailed analysis of numerous findings and issues relevant to the prevalence of adolescent eating disorders):

1. Between 1 and 6 in every 200 girls will develop anorexia nervosa between the ages of 12 and 20.
2. At any given point in time 6 to 10 percent of all high school girls are bulimic and 1 to 2 percent have a very serious bulimic disorder. If present trends continue, by age 20 as many as 1 in every 7 high school girls will be or will have been bulimic.
3. Given a prevalence of 1 to 3 percent for borderline eating disorders, in a class of 200 high school girls, 15 to 25 will *currently* be anorexic, bulimic, or borderline.
4. One to two percent of all boys will be bulimic during their high school years.
5. Available data are sparse and plagued by methodological problems, but it is likely that student eating disorders are becoming more prevalent than they were 10 years ago.
6. Recent research (see Chapter 7, p. 159) sug-

gests that at least 40 percent of all white, middle-class normal-weight girls attending suburban high schools are actively engaged in losing weight in order to become very thin.

7. One in five high school girls binge-eats on a regular basis, and 1 in 6 does so weekly. These rates are at least twice those reported by American college women, suggesting that the rate of binge-eating among younger girls is increasing.
8. A survey of nearly 1,300 girls attending a high school in Illinois found that 6 percent reported using diet pills at least weekly and 12 percent used them at least monthly. In general, it seems that today's high school students are more likely than previous ones to use evacuative methods (for example, self-induced vomiting), fasting, and diet pills to control their weight.
9. The age of onset for an eating disorder is highly variable, but, in general, the peak ages of onset for anorexia nervosa are 14 and 18, while those for bulimia are 16 to 18.

Although eating disorders are not, as some people have proclaimed, an "epidemic" on today's middle school, high school, and college campuses, they are distressingly prevalent. Moreover, they usually have serious and long-lasting negative effects on academic performance, interpersonal relationships, and general mental and physical health (see Chapters 2–5, 8, and 9). Even with highly skilled care, 30 to 50 percent of those bulimics and anorexics who do not receive attention early in their disorder will, like Karen, have chronic problems with eating, weight, health, and psychopathology (for example, depression) (5, 9, 12).*

*Instead of the awkward phrase "the person with anorexia nervosa/bulimia," I will use the nouns "anorexic(s)," "bulimic anorexic(s)," and "bulimic(s)." Because at least 90 percent of those with eating disorders are female, I will also use the feminine pronoun. Neither of these convenient practices should obscure two important facts, however: (1) people with anorexia nervosa and/or bulimia are individuals in terms of intelligence, personality, coping skills, interests, and so forth; and (2) males are not immune to eating disorders.

# The Goal and Guiding Principles of This Book

## Goal

This book is not meant to be a curriculum guide or a training manual. Its goal is to organize a great deal of potentially useful information into a single handbook that will enable and encourage school staff to prepare for the prevention of eating disorders via classroom instruction, improved detection and referral, and the professional development of school personnel. The information provided includes the following:

1. Facts about the nature and causes of anorexia nervosa (Chapters 2 and 8)
2. Facts about the nature and causes of bulimia (Chapters 4 and 9)
3. An extensive analysis of the sociocultural determinants of eating disorders (Chapter 7)
4. In-depth interviews with an anorexic adolescent and her parents (Chapter 3), and with a bulimic adolescent and her parents (Chapter 5)
5. Facts about the extent of eating disorders, the demographic characteristics of anorexics and bulimics, and the prevalence of dangerous weight control methods which seem to be on the verge of becoming normative among today's adolescents (Chapter 6)
6. Lists of specific resources—curriculum guides, readings, and films—that school staff can use to educate themselves and students about anorexia nervosa and bulimia (Chapter 10 and Appendix II)
7. General principles for discussing eating disorders with students in the classroom (Chapter 10, pp. 243–44)
8. General principles for identifying eating disorders and for referring anorexic and bulimic

students to the proper services (Chapter 10, pp. 253–56)

9. Suggestions for working with the entire school system (administrators, counselors, school nurses, and librarians) to educate students more thoroughly and to provide referral information more effectively (Chapter 10, pp. 256–62)
10 Names and addresses of the national eating disorders associations, accompanied by a description of their many services (Appendix I)
11. Suggestions and inspiration about the many creative ways in which teachers can integrate preventive education about eating disorders into basic lessons in important academic subjects (Chapter 10; the sections entitled "Conclusions and Implications" at the ends of Chapters 1, 4, and 6–10; and Table 8–1, p. 204).

## Guiding Principles

The development of this book was guided by a set of basic principles, some of which are facts and some hopeful assumptions. For quick reference, these are listed in Table 1–1. Given that the book is designed to educate school staff so that they may contribute to the prevention of eating disorders, their acceptance (or at least critical examination) of these principles for the purposes of preventive education and more effective advising constitutes another primary goal of this work.

*The prevention of eating disorders may be the most important aspect of efforts to combat eating disorders*. The number of adolescents and adults who suffer from anorexia nervosa and/or bulimia far exceeds the number of therapists with the expertise to help them. This means that two basic types of prevention are crucial to the elimination of eating disorders (see Chapter 10). Primary prevention is the attempt to prevent eating disorders from ever happening by eliminating or reducing risk factors. Secondary prevention is the early identification, accurate

Table 1-1. Guiding Principles for Combating Student Eating Disorders

1. The prevention of eating disorders may be the most important aspect of efforts to combat eating disorders.
2. Many middle school and high school teachers and staff members want to help prevent eating disorders.
3. Culture plays a significant role in the production and prevention of eating disorders, and the school is a significant part of culture.
4. Teachers can help fight the ignorance and misguided attitudes that contribute to eating disorders.
5. Students with anorexia nervosa and/or bulimia are people, not psychiatric entities.
6. Eating disorders affect a wide variety of students.
7. It is a major error to convey directly or indirectly that eating disorders are a "woman's problem."
8. Teaching about eating disorders requires extensive preparation because it is intellectually and emotionally demanding.
9. Teachers can promote understanding and constructive collaboration by avoiding simplistic pronouncements about "*the* cause" of anorexia nervosa or bulimia.
10. Teachers need to coordinate their preventive efforts with the work of experts and of other influential school personnel.
11. Teachers and school staff members are not therapists and, therefore, they should actively refrain from becoming involved in diagnosis and counseling.

referral, and prompt treatment of people whose eating disorders are in an initial phase.

Three facts suggest that school staff can play an important role in both types of prevention. First, adolescence constitutes the modal "age of onset" for both anorexia nervosa and bulimia (see Chapter 6). Second, school staff observe students regularly and often have an excellent, if at times poorly defined, sense of when something is wrong with them. Third, early identification and treatment of an eating disorder is associated with a significantly better prognosis for recovery (4, 8).

*Many middle school and high school teachers and staff members want to help prevent eating disorders*. They are very interested in the positive development of young people. Based on my experience with middle school and high school teachers in my area and on the enthusiastic response of many schools across the country to a curriculum guide I have developed in association with the National Anorexic Aid Society (10), I am convinced that many teachers and school staff want to know more about anorexia nervosa and bulimia so that they can apply their knowledge in the classroom and in their many contacts with troubled students and frightened parents.

*Culture plays a significant role in the production and prevention of eating disorders, and the school is a significant part of culture*. Culture is an important factor in psychopathology in general, and in eating disorders in particular (see Chapters 6 and 7). Since the school plays a very important role in the transmission of culture, the shaping of peer interactions, and the development of knowledge about the body and the self, teachers and their students can have a significant impact on the prevention of anorexia nervosa and bulimia. In order to do so, teachers, staff, and students must recognize the opportunity, if not the responsibility, to shift from inadvertent participation in a negative social process to active elimination of pernicious attitudes, expectations, and practices.

*Teachers can help fight the ignorance and misguided attitudes that contribute to eating disorders*. Eating disorders reflect a desperate need to be thin and a morbid fear of becoming obese. These motivations are based in part on individual pyschological problems, but they also develop out of a cultural context characterized by prejudice against nonslender people, restrictive attitudes about the meaning of femininity and of attractiveness for both sexes, and ignorance about weight regulation. Since teachers are devoted to the examination and eradication of both prejudice and ignorance, there is every reason to believe they can help prevent eating

disorders. From an academic perspective, the variety of sociocultural factors that contribute to eating disorders makes anorexia nervosa and bulimia fertile subjects for teachers of social studies, history, speech, home economics, health science, biology, and psychology (see Table 8–1, p. 204).

*Students with anorexia nervosa and/or bulimia are people, not psychiatric entities.* In general, students with anorexia nervosa and/or bulimia are not "crazies" who fall prey to an incomprehensible "mental illness." Rather, they are people—our students, our children, our colleagues, and our friends—struggling in comprehensible and often legitimized ways with insecurities, pressures, and ignorance that we as members of our culture have helped create or sustain. Teachers who wish to prevent eating disorders must join counselors, nurses, parents, and students in resisting the strong temptation to dissociate themselves from eating disorders by marveling at their bizarre signs and symptoms, giving them impressive psychiatric labels, and then turning over all responsibility for comprehending, identifying, and preventing them to experts.

In practice, this means that the prevention of eating disorders will be best accomplished not by using scare tactics, but by inviting school staff and students alike to think seriously about their own relationships to many of the factors underlying eating disorders: our cultural obsession with slenderness, sex-role stereotypes, dieting, the psychobiology of hunger, self-esteem, the developmenal stressors of adolescence, positive and negative coping strategies, and what it means to grow up (see Chapters 7–10). In other words, effective preventive education should remove anorexia nervosa and bulimia from the realm of clinical psychology and place them clearly in the context of the student's life.

*Eating disorders affect a wide variety of students.* Although there is a strong positive correlation between socioeconomic status and the prevalence of eating disorders (see Chapter 6), it is a dangerous myth that the only students susceptible to

eating disorders are rich and talented overachievers. Students with eating disorders, particularly bulimia, may be male or female, Black or white, rich or poor, conformist or rebel, good student or dropout.

*It is a major error to convey directly or indirectly that eating disorders are a "woman's problem."* Although girls are much more likely than boys to develop anorexia nervosa or bulimia, boys and young men are not invulnerable to eating disorders (see Chapter 6). It is very important that teachers try to explain the sex difference in the prevalence of eating disorders without obscuring the cultural, familial, biological, and individual factors that shape the development of anorexia nervosa and bulimia in both boys and girls (see Chapters 7–9).

*Teaching about eating disorders requires extensive preparation because it is intellectually and emotionally demanding.* This book is lengthy and detailed because the prevention of eating disorders involves many obstacles and challenges. Teaching about anorexia nervosa and bulimia requires at least some knowledge of these two multidimensional disorders (see Chapters 2 and 4), each of which has complex biological components and multiple causes (see Chapters 7–9). In addition, teachers need to examine their own beliefs and behaviors for evidence of a psychological investment in slenderness, unhealthy dietary restraint, and/or prejudice against overweight people. Finally, dedicated teachers face the formidable task of helping an image-conscious and self-conscious group of people examine such highly charged topics as body weight, body image, dieting, competition, sex roles, and coping with stress.

It is an article of faith that dedicated and creative teachers can use this book and other resources (see Chapter 10 and Appendixes I and II) to meet these challenges in ways that contribute to the prevention of eating disorders, staff development, and the fundamental education of adolescents.

*Teachers can promote understanding and constructive collaboration by avoiding simplistic pronouncements about "the cause" of anorexia nervosa or bulimia.* Each occurrence of an eating disorder is unique, and each is the product of a complex set of predispositions, precipitants, and perpetuators (see Chapters 8 and 9). There simply is no necessary or sufficient cause of anorexia nervosa or bulimia. For example, in some cases anorexia nervosa is attributable in large part to dysfunctional interactions within the family, whereas in other cases there is no evidence of disturbed familial relationships. In reply to some variation of the inevitable question "Who's fault is it?" I suggest the following: "Each case of anorexia nervosa/bulimia is different and each is the result of a number of forces within the person, the family, and our culture. What's really important is that the person, the family, and friends work together to get help for the eating disorder and to increase their ability to care for each other."

*Teachers need to coordinate their preventive efforts with the work of experts and of other influential school personnel.* There are two ideal and interrelated conditions necessary for effective preventive education in the classroom and for sensitive advising outside it (see Chapter 10). First, the efforts of teachers shoud be coordinated with the philosophy and functions of the school nurse, the librarian, the guidance counselors, the psychologist, and the administrative staff (for example, the curriculum director). Second, all these individuals should be trained and mobilized by an expert in preventive education for adolescents. It is highly recommended that teachers and administrators committed to the prevention of anorexia nervosa and bulimia contact a national eating disorders association (see Appendix I) for advice about staff development.

*Teachers and school staff members are not therapists and, therefore, they should actively refrain from becoming involved in diagnosis and counseling.* It requires considerable expertise and experience to help someone overcome an eating disorder,

and many anorexics and bulimics have suffered a great deal from bad advice offered by well-meaning but unskilled psychologists, physicians, social workers, etc. (6, 7). No matter how much they know about eating disorders, teachers must keep in mind that their significant contributions to the fight against eating disorders are preventive education, detection, and compassionate, well-informed referral.

## References


1. Anderson, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia*. Baltimore: Johns Hopkins University Press, 1985.
2. Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978.
3. Buss, A. H. *Psychopathology*. New York: Wiley, 1966.
4. Eckert, E. D. "Characteristics of Anorexia Nervosa." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 3–28. Minneapolis: University of Minnesota Press, 1985.
5. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.
6. Garner, D. M. "Why Obesity Should Not Be Treated." Workshop presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.
7. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.
8. Hsu, L. K. G. "The Treatment of Anorexia Nervosa." *American Journal of Psychiatry* 143 (1986): 573–81.
9. Johnson, C., and Connors, M. E. "Treatment of Bulimia: A Review." *Psychological Bulletin* (in press).
10. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS) 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

11. Rosenhan, D. L., and Seligman, M. E. P. *Abnormal Psychology*. New York: W. W. Norton, 1984.

12. Thompson, M. G., and Gans, M. T. "Do Anorexics and Bulimics Get Well?" In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 291–303. New York: Brunner/Mazel, 1985.

13. Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.

CHAPTER 2

# Anorexia Nervosa

Anorexia nervosa means "nervous lack of appetite." Technically, the phrase refers to a syndrome characterized by loss of appetite, aversion to food, and weight loss. This syndrome is observed in various psychological disorders, most notably depression and schizophrenia (4). But the psychiatric and popular use of "anorexia nervosa" reflects the way in which the phrase was first used by Dr. William Gull in 1868 (2): it refers to a distinct psychological disorder in which a drive for thinness and a fear of fatness result in life-threatening emaciation and a host of other problems that meet the IMAD criteria for determining abnormality (see Table 2–1).

Anorexia nervosa is a misnomer for this disorder. "Nervous lack of appetite" implies a lack of interest in food, and this is most certainly not the case with anorexics (8, 13, 23). Starvation causes virtually all anorexics to experience and indeed battle intense feelings of hunger. Although hunger is stubbornly denied, it is manifest in an obsessive concern with food, calories, diets, mealtimes, and food preparation. A more precise label for what is called anorexia nervosa is the German synonym: *Pubertätsmagersuch* or "leanness passion of puberty" (2). Despite the fact that a significant number of people develop anorexia nervosa well past the age of puberty, and despite the fact that this term is far too awkward for frequent use, it is worth remembering for its emphasis on the "passion" for slenderness as the central feature of anorexia nervosa.

## General Definition

Anorexia nervosa is a "*relentless pursuit of excessive thinness*" (5, p. ix, italics in original) that interferes with the fulfillment of responsibilities

## Table 2–1. Central Features and Commonly Associated Characteristics of Anorexia Nervosa

### CENTRAL FEATURES

1. An iron determination to become thinner and thinner
2. An extreme fear of becoming fat
3. Significant weight loss
4. A distorted body image
5. Difficulty in accurately interpreting hunger and other internal sensations (for example, anger)
6. Refusal to maintain a healthy body weight
7. Abnormal reproductive functioning

### EFFECTS OF STARVATION[a]

1. Obsession with food and food preparation
2. Unusual eating and drinking habits
3. Emotional disturbances
4. Social withdrawal
5. Binge-eating

### COMMONLY ASSOCIATED CHARACTERISTICS

1. Hyperactivity
2. Perfectionism coupled with a profound sense of ineffectiveness
3. Binge-eating
4. Purging via self-induced vomiting, laxatives, and/or diuretics

[a]Although there are significant individual differences in the ways in which people respond to weight restoration, many of the effects of starvation persist for at least several weeks after nutritional rehabilitation has been in effect.

to the self and to others (9, 22) because it produces an intense and irrational fear of becoming fat, an obsession with food and weight control, and a life-threatening weight loss. Eventually, a series of starvation-induced physical and psychological changes threatens control over eating and motivates more conscientious efforts to reduce. The result is a truly vicious circle of weight loss, hunger, and fear that will become a deadly noose if the process is not acknowledged and reversed (13).

## Natural History

The major features of anorexia nervosa are best understood as the end points of an insidious process (see Chapter 8 for more detail). This eating disorder usually begins innocuously. Although the future anorexic is often not at all or only slightly overweight, an insensitive remark or the perception of inadequate performance at school motivates her to diet seriously in order to flatten her stomach or hips, to "get in shape," or "just to lose a few pounds" (13).

Unlike most dieters, the anorexic-to-be relishes the opportunity to regulate food intake and body weight and thereby control the self (4). The entire enterprise unleashes a sense of potency and a supply of inexhaustible energy. At first she is extraordinarily capable of suppressing hunger and fatigue and of successfully immersing herself in schoolwork, athletics, dance, and so on (13). But after a time, "dieting" gives way to an extreme fear of losing control over eating and a compensatory need to rid the body of all flesh that can be construed as representing fat (14). If hunger is acknowledged, it is interpreted as a sign of an authentic and special self-control in an age of laxity and indulgence (5).

The ostensible reason for dieting is usually to become healthier and more popular, or to "get it together." The grim determination to sustain weight loss ultimately merges with the effects of

starvation to isolate the anorexic from her friends and family, to restrict her interests, to sabotage her schoolwork, and to threaten her physical well-being (13). As reducing becomes an obsession, the facade of adjustment crumbles.

## Major Characteristics

The central features of anorexia nervosa are difficult to specify because the disorder emerges over time as a complex mixture of the relentless drive for thinness, the effects of starvation, and commonly associated psychological disturbances (for example, low self-worth and mistrust of others) (2, 13). The following list (see also Table 2–1) is my compilation of prominent characteristics described by major theorists in the field—Andersen (2), Bruch (4), Eckert (9), Garfinkel and Garner (13), and by the American Psychiatric Association (1). Although these characteristics would not be accepted by everyone, they provide a convenient framework for discussing many of the basic features of anorexia nervosa.

### Significant Weight Loss

Experts agree that a significant weight loss is one of the cardinal features of anorexia nervosa, but they disagree over the definition of "significant." The program at Johns Hopkins Hospital operates on the premise that severe weight loss has taken place if the current body weight is incapable of supporting menstruation in females or sexual drive in males (2). For people under 18, the American Psychiatric Association (1) uses the criterion of a body weight loss of at least 25 percent from the sum of the original plus the projected gain based on a growth chart. It is difficult to say, however, what such a loss would mean if the individual were 25 percent or even 15 percent overweight originally (9). Similarly, in individuals who were initially underweight—say, 95 pounds at 5 feet tall—a loss of 10

percent of body weight could suppress menstruation (2) and create physical problems.

The suppression of menstruation or sexual functioning seems like a more meaningful sign of dysfunction than a fixed percentage of body weight lost, particularly because in 10 to 30 percent of the cases amenorrhea precedes a noticeable weight loss (13). But menstruation is a private and emotionally charged function, so cessation is not very helpful in detecting anorexia nervosa. As a rule of thumb, weight loss should not be considered the principal criterion for the determination of anorexia nervosa, but a loss of 10 to 15 percent should stimulate curiosity about the other central characteristics (23).

## The Drive for Thinness

The anorexic approaches weight loss with what Bruch (5, p. 5) calls an "iron determination." In fact, two of the world's foremost experts on eating disorders, Paul Garfinkel and David Garner of the Department of Psychiatry at Toronto General Hospital, maintain that "the central feature of anorexia nervosa is the individual's marked pursuit of thinness with the associated conviction that her body is too large" (14, p. 2).

It is crucial to note that the dedication to becoming thin is not equivalent to a phobic fear of becoming obese (see the next section). In a phobia, avoidance of the feared object or circumstance produces an uneasy relief. In anorexia nervosa, the weight loss is experienced by anorexics in the following terms: "accomplishment . . . sensuous delight . . . exhilarated . . . triumphant . . . powerful" (16, p. 110). Slenderness is highly valued in our culture (see Chapter 7). Moreover, as noted previously, starvation in a land of plenty is awe-inspiring, and for some adolescents emaciation and perpetual hunger are small prices to pay for distinction and a spiritual sense of mastery (5, 16).

## Extreme Fear of Becoming Fat

The drive for thinness produces an extreme fear of becoming fat (16). This sounds backward, but it is not. Battling hunger is a very difficult and unremitting task. The fear of losing control and becoming overweight creates anxiety that the anorexic welcomes because it sustains the vigilance required to become thinner and thinner.

This anxiety seems completely irrational to others. How can someone be terrified of getting fat when he or she looks more and more like a concentration camp inmate with each passing week? The key to this enigma is the fact that the body overcompensates for significant weight loss in many ways, including an increase in hunger and a decrease in the ability to stop eating after intake of only a small amount (see Chapter 8). Thus, the fear of losing control has a realistic basis and, in some cases, is reinforced by terrifying episodes of binge-eating (13).

The phobic fear of weight gain expresses itself in a number of ways. Most anorexics weigh themselves several times each day and respond to slight but normal increases with extreme anxiety (9). As insurance against the possibility of weight gain, they may eat only one carefully planned meal each day and keep a detailed record of every calorie consumed and expended. They divide foods into "safe" and "dangerous" categories, with the latter becoming larger at the expense of the former as time goes on. Having eaten, the anorexic may be so anxious about the prospect of weight gain that she feels compelled to induce vomiting, exercise until she is exhausted, or take laxatives. All these phobic behaviors are physically and emotionally draining, but the stark truth is that anorexics are more afraid of becoming fat than they are of dying (23).

## Distorted Experience of the Body

Most anorexics have two significant disturbances in the perception and interpretation of

messages from their own bodies. Misperceptions of external body shape constitute a "distorted body image," while inaccuracies in the experience of internal sensations such as hunger or anger are called "disturbances of interoceptive awareness" (4, 13, 14).

### *Distorted Body Image*

There are two types of distorted body image (14). The most commonly reported is a perceptual disturbance in which the anorexic seems literally unable to "see" how thin she has become. The "inability to recognize her appearance as abnormal" (13, p. 125) often takes on the features of a delusion as she vigorously insists that her emaciated figure is just right or even too fat. This distortion is confined to the anorexic's perception of her own body; her perception of things outside her body, including the size of other anorexics, is as accurate as that of anyone else (14). Some anorexics can see that certain parts of their bodies are too thin, but insist that their stomachs, thighs, and hips are "fat" and in need of further reduction.

The second type of body image distortion is emotional rather than perceptual. These anorexics can see that they are too thin, but they either rejoice in this "achievement" or they cling to slenderness as protection against a body that they loathe in its normal form (13). The distinction between those anorexics who markedly overestimate their body size and the more accurate perceivers is an important one (14). Overestimators tend to be more depressed and psychologically disturbed, and their prognosis for recovery is significantly worse. For them the combination of perceived obesity and low self-esteem seems to generate a particularly intense and refractory drive for thinness (14).

### *Disturbances of Interoceptive Awareness*

Most anorexics have great difficulty in accurately interpreting hunger and other internal

sensations such as sexuality, emotions, and temperature (4, 5). They may deny or confuse hunger impulses with other strong emotions. Their experience of satiety is also disrupted, and therefore the tendency to binge-eat may alternate with "endless complaints of acute discomfort and fullness after the intake of even small amounts of food" (4, p. 252).

In general, anorexics are as out of touch with their emotions as they are with their bodily sensations concerning hunger. Often they do not know what they are feeling or how to express it, a condition known as "alexithymia." Many feel hollow or blank inside, incapable of experiencing anger or finding a genuine sense of pleasure in anything but weight loss (13). Some of these interoceptive disturbances are attributable to starvation, but often the problem remains after weight restoration (2, 13). The misperception of motives and feelings, in combination with the anorexic's chronic struggle to control hunger, creates a fundamental mistrust of the body that must be overcome if therapy is to be successful (13).

## Refusal to Maintain a Healthy Weight

The interplay among the drive for thinness, the fear of fatness, and the distorted body image produces an antagonistic refusal to maintain a healthy body weight. Hospital nurses report that, even under intense scrutiny, anorexics will surreptitiously attach pats of butter to the underside of trays and gracefully spit pieces of partially chewed meat into milk containers (2). Since the anorexic angrily denies she is ill, she resents the intrusions of parents, friends, and physicians, whom she perceives as conspiring to force her to eat and become fat (23). This refusal to eat often results in unpleasant struggles for control, but it is important to understand that the anorexic's motive is usually fear of weight gain and not aggression (13).

### Abnormal Reproductive Functioning

For females an important sign of anorexia nervosa is a delay in menarche (primary amenorrhea) or a cessation of menstrual periods (secondary amenorrhea) (2). For males the corresponding sign is impotence and infertility caused by a substantial drop in levels of testosterone. Some experts believe that deficits in reproductive functioning are due entirely to starvation, but others point to two facts that contradict this simple explanation. First, as noted previously, in as many as one-third of the cases amenorrhea precedes a noticeable weight loss (3, 9). Second, in a significant number of cases amenorrhea persists long after a weight sufficient to initiate or restore menstruation has been attained (2). This controversy is not yet resolved, but most experts include abnormal reproductive functioning as a criterion for anorexia nervosa.

## The Effects of Starvation

Descriptions of anorexia nervosa have emphasized many more symptoms than those given here. For example, Levenkron (21) connects anorexia nervosa with obsessions, compulsions, paranoia, and depression. It is true that a number of psychological problems are commonly associated with the central features of anorexia nervosa. However, many of these are caused by starvation.

During the late 1940s researchers at the University of Minnesota studied the long-term effects of a semistarvation diet on 36 *male* conscientious objectors who volunteered for the research (Keys and others [19], as reviewed in Bruch [5], Garfinkel and Garner [13], Garfinkel and others [15], Garner and others [18]). None of the men was anorexic. In fact before the study began, the investigators carefully determined that each of the men was physically healthy and psychologically well-adjusted.

What follows are a few of the many striking parallels between some of the commonly

noted features of anorexia nervosa and the effects of a semistarvation diet on normal males (for a fuller comparison, see Garner and others [18]).

## Obsession

Although anorexics stubbornly refuse to eat, they are often preoccupied with food and food preparation. They "savor" collecting, reading, and talking about books on cooking or nutrition. Some anorexics will secrete food from the table and hoard it in their room, as if planning to eat it later. As the male volunteers in the Minnesota study lost a significant amount of weight, they became similarly obsessed with food, eating, and cooking, to the point where they could concentrate on very little else. The hoarding of food and cooking utensils was commonly observed. Several of the men found themselves thinking about careers in food preparation, and three became chefs after the experiment concluded.

## Unusual Eating and Drinking Habits

Many anorexics develop strange ways of consuming what little food they allow themselves to eat. For example, they may cut each piece of meat into four identical pieces. Then they will eat only three of them, making sure that the fork does not touch their lips and that they chew each chunk exactly 12 times. Sometimes they mix foods in strange ways, such as putting vinegar and sugar on a piece of lettuce. Some anorexics "live on" diet soft drinks or coffee. The list of rituals, bizarre practices, and oral habits goes on and on, but the important point is that every one of them was observed in the semistarved male volunteers.

## Emotional Disturbance

Descriptions of anorexics commonly note their depression, anxiety, and contentiousness. Although the men in the Minnesota study were

carefully screened to exclude the emotionally unstable, semistarvation produced profound emotional changes. In general, the threshold for negative emotional reactions was lowered. In response to little or no provocation, the men became depressed, angry, and anxious. Some became apathetic and overly attentive to what ordinarily would be minor aches and pain. Two of the men became grossly disturbed and were hospitalized for psychiatric treatment. Interestingly, some of the men became even more difficult to get along with when they were permitted normal access to food again. This strengthens the conclusion that the process of starvation creates powerful emotional disturbances above and beyond the impact of obvious nutritional deficiencies.

## Social Withdrawal

One of the reasons that anorexia nervosa is so devastating for the family is that self-absorption makes the anorexic oblivious to the needs of others. This is due in part to the fanatical drive for thinness, but the Minnesota study indicates that social withdrawal is also a result of starvation. As starvation progressed, the men became more self-centered, inexpressive, and isolated. Dealing with others became "too much trouble" or "too tiring." Sexual interests and activity ceased almost completely. As was the case for emotional stability, all these indices of self-absorption persisted long after weight restoration began.

## Binge-Eating

From one-third to one-half of all anorexics periodically lose control of their prodigious hunger and proceed to eat tremendous quantities of food. These episodes of bulimia ("ox hunger") were also observed in some of the Minnesota volunteers during the starvation phase. During the rehabilitation phase, many engaged in binge-eating, and a startling but extremely significant finding was an increase in their hunger following a large meal.

### Implications of the Minnesota Starvation Study

This research is fundamental to understanding and teaching about both anorexia nervosa and bulimia. It suggests that chronic and extreme dieting of the type practiced by many adolescent girls, some adolescent boys, and a fair number of educators of both sexes has very negative psychological effects. Since the weight loss efforts of anorexics are by definition more extreme, the psychological effects of starvation form an important part of the eating disorder. Unless they persist after weight restoration, however, depression, self-absorption, and so forth should be considered significant by-products of starvation that are intensified by the drive for thinness and the fear of becoming obese (2).

The Minnesota study also highlights the basic paradox that engulfs the anorexic (13). The drive for thinness and the fear of obesity sustain the process of starvation. But starvation results in an obsession with food and eating, a tendency to binge-eat, and decreases in alertness, ambition, and energy, all of which threaten the anorexic's commitment to weight loss and control of herself. The anorexic's response to this challenge is to tighten her belt and her lips in further resolve to get thin. Although self-destruction is not her motive, the end result of the battle with starvation is the tightening of a noose.

## Commonly Associated Characteristics

### Hyperactivity

Unlike people who are starving because food is unavailable, anorexics may have an extraordinary amount of energy in the initial stages of their illness (9, 22, 7). "This energy is usually

expended in activities which contribute to weight loss, such as dancing or doing calisthenics, but it can also be expressed in any activity which contributes to the all-important sense of control" (22, p. 22; 9). Initially, the "driven" quality of these activities meets the approval of parents, coaches, and friends who encourage self-sacrificing dedication to achievement. As time goes on, however, the hyperactivity assumes a ritualized and compulsive nature that isolates the anorexic from the flow of everyday life (9).

## Perfectionism and a Profound Sense of Ineffectiveness

According to Hilde Bruch (4, 5), a world-renowned expert on anorexia nervosa, the stubborn and defiant drive for thinness is a compensation for an undifferentiated and intense feeling of helplessness. This is consistent with the clinical observation that many anorexics see themselves as stupid and ineffectual in a world filled with complex challenges (23). Although the world of today's adolescent is indeed complex and challenging, the anorexic's low self-esteem is built upon an all-or-none perfectionism that has no room for failure or degrees of success (13; see Chapter 8 of this book).

When a profound sense of ineffectiveness is coupled with extreme perfectionism and unmistakable talent, as is often the case, the result is alienation from self and from others. Self-acceptance crumbles in the face of unrelenting pressure to do well and the conviction that whatever is accomplished will not be enough. Other people, seeing only talent and drive against the backdrop of a "good home," cannot relate to the anorexic's insecurities. Paradoxically, the belief that failure and loss of control are always just around the corner may be responsible for the compulsive insistence on orderliness, structure, and goodness that keeps other people at a distance (23).

# Anorexia Nervosa with Bulimic Complications

The continuum of eating disorders presented in Chapter 1 makes it clear that anorexia nervosa and bulimia are not entirely distinct eating disorders. According to several recent reviews, between 10 and 47 percent of anorexics engage in bulimic behavior (9, 12). That is, they have episodes of binge-eating followed by purging in the form of self-induced vomiting or abuse of laxatives and diuretics.

In this regard experts speak of restricting versus bulimic anorexics (13, 17). The utility of this division is supported by the finding that bulimic anorexics are significantly more disturbed than restricting anorexics (9, 18, 23). Although the bulimic group tends to be more extroverted and sexually experienced, the instability of their eating habits seems to extend to many aspects of their lives. As a group they are more emotionally unstable, more impulsive, more likely to complain of various aches and pains, more likely to report extreme conflict within their families, and more prone to the abuse of alcohol and drugs (2, 18, 23). In addition, before the onset of illness, bulimic anorexics are more likely than restrictors to have been overweight and to have had interpersonal difficulties interspersed with depression, anxiety, and erratic changes in moods (12, 18). Ironically, although bulimic anorexics are more likely to admit their illness and participate in treatment, their long-term prognosis is poorer, probably as a function of a more disorganized personality and the addictive qualities of bingeing and purging (9).

Researchers are continually extracting and evaluating new subgroups of anorexics, such as those who vomit versus those who do not. The principal implications of this research for school staff are as follows:

1. Efforts to delineate meaningful subgroups should

not obscure the fact that each anorexic is an individual with complex feelings, behaviors, and values that are distinct from the drive for thinness and fear of fatness shared with other anorexics.

2. Not all anorexics correspond to the stereotype of the perfectionist, compliant, and sexually naive adolescent.
3. Although a good deal of further research is needed to determine the significance of diagnostic subgroups for the prevention and treatment of anorexia nervosa, bulimic anorexia seems to be more closely related to bulimia (see Chapter 4) than to restricting anorexia nervosa.

## Anorexia Nervosa Versus Other Psychological Disorders

Given an increased public awareness of anorexia nervosa, it is important that education employees and others interested in adolescents not interpret every significant loss of weight as anorexia nervosa. Here are a few disorders that may be confused with anorexia nervosa (5, 13, 15).

### Endocrine Disorder

Addison's disease, which compromises the functioning of the adrenal glands, produces symptoms that superficially resemble anorexia nervosa (6, 13). Victims lose weight, vomit, eat very little, show little interest in sexuality and socializing, and have lowered blood pressure and body temperature. Generally they are very concerned about their rapid weight loss, however, and they try hard to keep food down. In addition, in Addison's disease patients, unlike victims of anorexia nervosa, the potassium levels are elevated instead of reduced (13).

## Psychogenic Malnutrition

"Psychogenic malnutrition" refers to an extreme loss of weight that has a psychological origin—that is, it has no known physical cause (4, 23). This would apply to a depressed person whose lack of motivation and general withdrawal encompasses a loss of interest in food. It would also be the appropriate label for the nutritional status of a paranoid schizophrenic whose refusal to eat is based on the delusion that the food is poisoned or possessed of evil powers.

## Conversion Disorder

In a conversion disorder the patient unconsciously converts an intolerable emotional conflict into the symptoms of face-saving physical illness (1, 24). In some cases conflicts over sexuality or dependence are converted into loss of appetite, problems with nausea and indigestion, and uncontrollable vomiting after any sort of food intake. These patients may be mistaken for anorexics because their ostensible concern about emaciation and their willingness to cooperate with weight restoration efforts are contradicted by their resistance to therapy and their comfort with the role of patient (15). In these patients the denial of hunger and the inability to keep food down indirectly communicate distress about interpersonal problems; they do not represent a drive for thinness.

## Significance

Consideration of other disorders in which appetite is reduced and weight is lost highlights the distinctive features of eating disorders in general and anorexia nervosa in particular. As Andersen (2) emphasizes, the diagnosis of anorexia nervosa should be based on the presence of "positive" signs, not the exclusion of other disorders.

These signs, each of which is missing in the preceding disorders, are as follows:

1. A drive for thinness
2. A morbid fear of becoming fat
3. A distortion of body image
4. The refusal to eat properly despite an obsession with food
5. Dangerous methods of reducing and/or purging
6. Episodes of binge-eating.

## The Effects of Anorexia Nervosa

### Psychological

As the illness progresses, anorexics experience severe psychological turmoil. Chronic anxiety about weight gain and appearance, the effects of malnutrition on the brain, the severe stress involved in combating the body's natural inclination to maintain weight at a healthy level, and, in some cases the very real threat of binge-purge episodes—all take their toll. Over time the anorexic becomes irritable, hostile, indecisive, depressed, defiant, and resistant to change (23). The obsession with reducing and the effort necessary to overcome a mounting hunger create a fog that blankets normal psychological functioning, leaving the anorexic at times in what amounts to a dissociated state (5).

### Physical

The physical effects of anorexia nervosa represent the intersection of starvation, chronic stress, and the abuse of weight control methods such as overexercising, self-induced vomiting, laxatives, and diuretics (10, 13). The effects of starvation and purgatives can be severe and even fatal. Currently,

the mortality rate is between 2 and 3 percent (2, 13), but it has been as high as 10 percent in the past (13). Thus, even though an anorexic says she "feels fine" and her parents claim "she is very active and healthy as a horse," it is important that all anorexics receive careful medical evaluation (2).

### *Starvation*

Starvation has at least a score of negative effects on psychological and physical functioning (2, 10, 13). Those that sabotage the anorexic's battle with hunger and significantly threaten her health include the following:

1. Numerous problems with the brain-body systems that regulate basic bodily functions. Thus, sleep is disrupted, it is difficult to stay warm, and sexual drive is decreased.
2. Cardiovascular problems such as slow, irregular heartbeats and a drop in blood pressure. These result in light-headedness and dizziness that worsen during exertion.
3. Muscle wasting and muscular weakness.
4. Susceptibility to severe and sometimes fatal illnesses, such as bronchopneumonia and kidney or cardiac failure.

Starvation also has some less severe effects that may serve as warning signs of anorexia nervosa (see Table 10–1, pp. 254–55):

1. The hair on the head becomes thin and brittle and begins to come out in clumps during combing.
2. A fine, raised white hair called "lanugo" appears on the cheeks, neck, forearms, and thighs, probably to conserve heat.
3. Gastrointestinal symptoms, including chronic constipation and abdominal discomfort (bloating), follow ingestion of even a small amount of food.
4. The palms and soles of the feet may become

yellowish in appearance from a diet consisting primarily of vegetables such as carrots. These vegetables contain a yellow or red plant pigment called carotene.

### *Weight Regulation Methods*

Repeated self-induced vomiting has a variety of negative effects on each component of the digestive system (13, 10, 25, 26). The backwash of vomitus produces unusual patterns of enamel erosion and tooth degeneration, a process that is compounded by decreases in the ability of the saliva to serve its protective function. The throat and esophagus may be chronically sore or otherwise irritated, and the person may complain of difficulty in swallowing. Chronic vomiting can also cause lesions in the esophagus, and, in rare cases, a rupture will be fatal. The stomach is adversely affected in ways that worsen the bloating and digestive pain produced by starvation.

The major danger of self-induced vomiting and the abuse of diuretics is a disruption of the potassium-sodium balance necessary for the proper functioning of nerves and muscles, including the heart. Low potassium levels, called hypokalemia, can develop without much warning. The result is fatigue, muscle weakness, muscle spasms (tetany), diminished reflexes, and a worsening of depression and irritability. Abuse of diuretics also contributes to dehydration, which magnifies the weakness and light-headedness created by starvation and hypokalemia. Severe hypokalemia can cause convulsions, irregular heartbeats, and fatal heart or kidney failure. Unfortunately, research suggests that the effects of hypokalemia may be particularly pronounced and even deadly during the type of intense and prolonged exercising seen in many cases of anorexia nervosa.

The abuse of laxatives exacerbates the digestive problems created by starvation. For example, stomach discomfort, cramping, and, para-

doxically, constipation are all worsened by chronic laxative abuse. Such abuse also leaves the anorexic weaker by making it more difficult for the intestines to absorb fat, protein, and calcium. In cases of extreme abuse the bowel becomes completely dysfunctional.

It is important to note that some anorexics and bulimics induce vomiting by ingesting syrup of ipecac (11, 28). This product is available over the counter, and many parents buy it as a first aid measure that enables them to stimulate vomiting rapidly in cases of accidental poisoning. Chronic use of syrup of ipecac as a weight regulation method creates all the dangers of repeated vomiting, plus another, more deadly one. Syrup of ipecac contains emetine. With repeated use, emetine builds up in the heart, weakening it dangerously. The much publicized death of anorexic singer Karen Carpenter was attributable to emetine poisoning.

### *Chronic Stress*

Anorexia nervosa is both a cause and an effect of psychological distress. Consequently, the physical effects of anorexia nervosa reflect the impact of chronic anxiety, tension, and depression on the human body. In general these effects intensify the disturbances of hunger, satiety, sleep, and sexuality produced by starvation.

## Social

The anorexic's initial commitment to dieting is often based on a desire to be more popular or attractive. As the illness progresses, however, the anorexic becomes increasingly alienated from other people (4, 7, 13). Obsession, fear, and starvation make anorexia nervosa a lonely enterprise that bewilders, horrifies, and antagonizes others. One recent study found that in general anorexics "lead depressing, restricted, and joyless lives, with feelings of personal inadequacy at work, and often overwhelming social and family problems" (27, p. 56).

# Teaching About Anorexia Nervosa: Conclusions and Implications

## Definition

*Conclusion.* Anorexia nervosa is a misnomer because it means "nervous lack of appetite." In fact, anorexia nervosa should be thought of as a drive for thinness, an irrational fear of weight gain, and a distorted experience of the body. Together these experiences produce fanatical measures designed to suppress a mounting sense of hunger and a concomitant preoccupation with food.

*Implication.* Discussions of anorexia nervosa should deemphasize weight loss and debunk the myth that anorexics have conquered hunger.

## The Effects of Starvation

*Conclusion.* The anorexic envisions slenderness as the solution to life's problems. But most people are not "designed" to be extremely thin, and thus the anorexic's efforts to reduce constitute starvation. Starvation produces an obsession with food and eating, emotional disruption, social withdrawal, and a tendency to binge-eat. In other words, starvation generates a number of negative effects that intensify many of the same problems that reducing was designed to solve.

*Implication.* A conscientious discussion of anorexia nervosa, one that tries to capture both the comprehensibility and the irrationality of the anorexic's motives, should include a section on the physical and psychological consequences of starvation.

## Anorexia Nervosa with Bulimic Complications

*Conclusion*. A significant number of anorexics periodically lose control over their hunger and binge-eat. The prospect of weight gain and the uncertainty produced by episodic helplessness propel these bulimic anorexics to try to rid themselves of the calories by self-induced vomiting, laxatives, and fasting. But purging only intensifies hunger and weakens the ability to resist it, thus setting the stage for engulfment by daily or even hourly binge-purge cycles. Those anorexics who are prone to bulimic complications tend to lead chaotic lives characterized by impulsivity, emotional instability, and overt family conflict.

*Implication*. The existence of bulimic anorexia emphasizes two major points. First, it reinforces the critical point that the battle with starvation is a dangerous one. Second, not every anorexic is "the best little girl in the world" (20).

## Consequences of Anorexia Nervosa

*Conclusion*. Anorexia nervosa is self-destructive and potentially fatal, but the dieter who becomes anorexic does not intend to commit suicide. On the contrary, this person hopes to gain control by achieving a highly valued state in our culture, that of being slim and trim (see Chapter 7). For reasons not yet fully understood (see Chapter 8), in certain people dieting unleashes a fanatical commitment to weight loss. This obsession is ultimately self-defeating but self-perpetuating. Specifically, anorexia nervosa produces starvation, chronic psychological stress, and physical abuse. These effects ensnare the anorexic in a web that builds fatigue, confusion, and inadequacy around an expanding core of anxiety-dieting-hunger-anxiety-dieting-hunger. Seeking vigor, the anorexic creates weakness; seeking control, the anorexic manufactures helplessness; and seeking

connection, the anorexic finds herself completely alone. At the beginning, suicide was far from the intention; at the end, it is a distinct possibility.

*Implication.* Understanding the trap of anorexia nervosa is an important means of avoiding authoritarian scare tactics and empathizing with the authentic concerns of adolescents. Conceptualizing anorexia nervosa as the breakdown of coping strategies that are culturally approved and initially successful sets the stage for an effective discussion of adolescent stressors and both negative and positive means of adjusting. It also humanizes the disorder by encouraging teachers and students alike to think about their own relationship to many of the topics covered in subsequent chapters: dieting, self-esteem, our cultural obsession with slenderness, biological weight regulation, and sex roles.

## References


1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (DSM–III). 3d ed. Washington, D.C.: APA, 1980.
2. Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia.* Baltimore: Johns Hopkins University Press, 1985.
3. Bemis, K. M. "Current Approaches to the Etiology and Treatment of Anorexia Nervosa." *Psychological Bulletin* 85 (1978): 593–617.
4. Bruch, H. *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within.* New York: Basic Books, 1973.
5. _____. *The Golden Cage: The Enigma of Anorexia Nervosa.* Cambridge: Harvard University Press, 1978.
6. Carroll, B. J. "The Hypothalamus-Pituitary-Adrenal Axis in Depression." In *Handbook of Studies on Depression,* edited by G. D. Burrows, pp. 325–41. New York: Excerpta Medica, 1977.
7. Casper, R. C., and Davis, J. M. "On the Course of Anorexia Nervosa." *American Journal of Psychiatry* 134 (1977): 974–78.
8. Crisp, A. H. *Anorexia Nervosa: Let Me Be.* Orlando, Fla.: Grune and Stratton, 1980.

9. Eckert, E. D. "Characteristics of Anorexia Nervosa." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 3–28. Minneapolis: University of Minnesota Press, 1985.

10. Enright, A. B., and Sansone, R. "Medical Complications in Eating Disorders." *NAAS Newsletter* 6 (January–March 1983): 1, 4. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

11. Friedman, E. J. "Death from Ipecac Intoxication in a Patient with Anorexia Nervosa." *American Journal of Psychiatry* 141 (1984): 702–3.

12. Gandour, M. J. "Bulimia: Clinical Description, Assessment, Etiology, and Treatment." *International Journal of Eating Disorders* 3 (1984): 3–38.

13. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.

14. Garfinkel, P. E., and Garner, D. M. "Perceptions of the Body in Anorexia Nervosa." In *The Psychobiology of Anorexia Nervosa*, edited by K. M. Pirke and D. Ploog, pp. 136–47. Berlin: Springer-Verlag, 1984.

15. Garfinkel, P. E., and others. "Differential Diagnosis of Emotional Disorders That Cause Weight Loss." *Canadian Medical Association Journal* 129 (1983): 939–45.

16. Garner, D. M., and Bemis, K. M. "Cognitive Therapy for Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 107–46. New York: Guilford Press, 1985.

17. Garner, D. M.; Garfinkel, P. E.; and O'Shaughnessy, M. "The Validity of the Distinction Between Bulimia With and Without Anorexia Nervosa." *American Journal of Psychiatry* 142 (1985): 581–87.

18. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.

19. Keys, A., and others. *The Biology of Human Starvation*. 2 vols. Minneapolis: University of Minnesota Press, 1950.

20. Levenkron, S. *The Best Little Girl in the World*. Chicago: Contemporary Books, 1978.

21. _____. *Treating and Overcoming Anorexia Nervosa*. New York: Charles Scribner's Sons, 1982.

22. Levine, M. P. *The Psychology of Eating Disorders: A Lesson*

*Plan for Grades 7–12.* Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

23. Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists.* New York: Van Nostrand Reinhold, 1983.
24. Rosenhan, D. L., and Seligman, M. E. P. *Abnormal Psychology.* New York: W. W. Norton, 1984.
25. Sansone, R. "Overview of Medical Complications in the Treatment of Eating Disorders." Paper presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.
26. Schermer, T. W. "The Medical View of Anorexia Nervosa and Bulimia." *Kenyon College Alumni Bulletin* 9 (Winter 1985): 13–15. Available from Dr. Tracy W. Schermer, Director, Health and Counseling Service, Kenyon College, Gambier, OH 43022 (614–427–2244).
27. Thompson, M. G., and Schwartz, D. M. "Life Adjustment of Women with Anorexia Nervosa and Anorexic-like Behavior." *International Journal of Eating Disorders* 2 (1981): 47–60.
28. Tootell, C. "Syrup of Ipecac Warning." *NAAS Newsletter* 7, no. 11 (July–September 1985): Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1102).

CHAPTER 3

# Vicki's Story: The Personal Side of Anorexia Nervosa

A description of the general signs and symptoms of anorexia nervosa simply cannot capture the intensely personal side of this tragic eating disorder. This chapter presents the introductory portions of very lengthy interviews that I (*ML*) conducted separately with an 18-year-old Caucasian girl (referred to as "V" for "Vicki") and her upper-middle-class parents.

## The Adolescent

*ML*: How and when did your problems begin?

*V*: I was in the eighth grade. That summer I visited my grandparents. At my grandparents I would get up in the morning, and sometimes I would stretch out or something. This really impressed my grandparents, because my cousin was a little bit overweight and, although I was just about normal for my size, I did exercise. So I was special. I liked to do things for my grandparents. I would vacuum, and I'd mow the lawn for them, and I started running and they just thought that was wonderful, because I was really active and I wasn't lazy, because my grandmother isn't lazy at all. And so I had a really good time there.

My parents and I left there, and on the way home I said, "Why don't we all three go on a diet together?" My mom and dad liked the idea—because everyone talks about it and because we were

coming home from vacation and stuff, and everyone thought they had gained weight, and so we never really mentioned it again.

*ML*: What made you suggest going on a diet together?

*V*: Well, I had started to think about weight, and I was just starting to develop. I remember I had just gotten new clothes, and when I put them on I just realized I was looking different. And I had also started to wear makeup for the first time because I remember my grandmother asked me to take it off. I was trying kind of to be old, but then I liked being the baby, and especially now since I was just the baby left with my mom and dad. I felt confused about which way to go.

When I got home I was real excited about starting high school. I made the varsity soccer team, and this is when I really started to think about exercising and not eating.

*ML*: I'm still not clear why you decided to diet.

*V*: I really don't know what made me actually decide. I liked how I was starting to look, but then I decided I would look a little bit better if I just weighed a little bit less.

*ML*: How tall were you and how much did you weigh at that time?

*V*: I was 5'4" and about 105. I remember because I had just gone over 100. And 100 pounds just stuck in my mind . . . .

*ML*: When you got back home from your grandparents' and began trying out for the soccer team, were you dieting then?

*V*: I was just starting to run. No, I was eating normal but I was trying to cut out some of my eating, mostly fats, and then I started cutting out my snacks because I used to just come home from school and eat like a horse. Then I stopped eating lunch. It was a big deal, because we would all eat lunch at high school together, and people started noticing when I said, "Well, I'm dieting, I'm not eating my lunch."

At first it wasn't a big deal because I wasn't looking like I was losing weight or anything.

So I kept exercising, but my exercising was getting to be very compulsive. Coming home I'd jump off the bus and start running, and the girl that lived next door would take my books and drop them off at the front door. And then I started trying to find ways that I could lose more—that I could start to sweat more, because I always felt so good after I had run. So I started putting saran wrap on.

*ML*: Did you run regardless of the weather?

*V*: Oh, yes. It was like hell bent for nothing, you just went. I felt really strong. I'd run, and then I'd go to soccer practice. But that was all that I was doing really, just running and doing soccer practice.

*ML*: Did you do exercises in the morning?

*V*: I started doing stuff for my stomach just before I'd get up in the morning. But it wasn't something that I thought about or planned ahead. That went on for a few months. Then I started to lose weight and it was starting to show. I wasn't thinking of it, but at school people were saying, "Gee, you look really good." I was looking thinner, so I was probably down around 99 or 97.

Then people stopped saying stuff to me, so I thought, "Something's wrong here. I'll lose five more pounds and get down to like about 92 or around there." And then I had my eye set on 90, and so I started losing more weight. By this time my mom and dad were starting to notice a change. They weren't really concerned, but they were starting to get concerned. They'd ask me, "Are you eating?" "Sure I'm eating." But I wouldn't eat and I had started kind of doing things in my head, planning ahead what to say to get out of things. I would not eat breakfast because I'd get up before them to go to school. I didn't eat lunch because I was at school, but I'd tell them, "Sure, I had something." Then I would go to soccer and I'd come home and I'd have just a little bit; I was starving, so I had to have something.

*ML*: Were you hungry throughout all this?

*V*: Yeah, I was really hungry, but I was trying to eat things that normal people eat on diets like chicken noodle soup or cottage cheese. Then every night before I'd go to bed I'd have like a big diet drink or a slush, so it looked like I was just eating in the normal way.

Then my face started to get shrunken, and my parents took me to a doctor. I didn't want to go, because I thought they were crazy to think anything was wrong. But it was getting to the point where my mom and dad were saying, "You can't exercise," and I was like, "You can't tell me what to do." I especially wanted my dad to see me running in the pouring rain, but I didn't want to talk to him about it. I liked the fact that I was doing something even though he may not want me to.

*ML*: Were you able to play soccer without eating?

*V*: I was able to play, but I was starting to feel really run-down. And when I was in school, all I would think about was food all day long, I was so hungry, but I wouldn't eat. No way. Especially at school, because I really felt good there.

*ML*: Did you have trouble concentrating on your schoolwork?

*V*: Oh my God, I didn't even think about schoolwork. Schoolwork was, like, dropped. It was funny because I had always been a really good student and schoolwork had come first. But then it just kind of took a back seat; just this eating—food, food, food—came first.

*ML*: Did you think about eating or did you think about calories?

*V*: Oh, God, I started calculating calories—I memorized calories. I was starting to get really involved with food and I was moving, just kind of moving away from my friends, because they were into eating. We were just kind of getting into separate little worlds.

*ML*: What happened when your parents took you to see the doctor?

*V*: He weighed me and I think I was around 96 or 97. He said, "'I want you to write down for the next two weeks what you eat." I said, "Fine, let's go home." Over the next two weeks I lost ten pounds. I was around like 87.

*ML*: You lost ten pounds in those two weeks?

*V*: Yeah, and the doctor told my mom and dad, "She needs to go to a hospital right away." I remember when I went to see him the second time I was feeling really good, because I was wearing these pants I had worn when I was real young, and I was just feeling so thin, it was just great.

*ML*: So you didn't feel badly? You didn't feel that you needed to go to a doctor?

*V*: No. I didn't know what it was all about really.

*ML*: Were you angry?

*V*: A little bit, because I kind of felt like someone was tampering with the world I was making for myself, and I didn't like it.

*ML*: What was school like at this time?

*V*: Things started to get really bad. I was getting really thin and trying to cover for it, but in another way I wasn't trying to cover for it. I was wearing baggy clothes, but even with baggy clothes you could notice it. I'd go through the halls and people would say my nickname: "Annie" for anorexic. . . . That was just sick, but some of the ones who did it were sick. But I was getting noticed. In high school you don't get noticed, you're just a little nerd freshman they want to squish on. And my soccer was coming to an end, which was good because it was getting to be too much. . . .

*ML*: Were you still exercising at this time?

*V*: Yeah, my exercising became A-number-one important, before soccer or everything.

*ML*: At this time what kind of food and how much might you eat in the course of a day?

*V*: I wasn't eating any breakfast or lunch. So probably all I was eating was around three or four hundred calories. Not much. At this point it wasn't hard for me not to eat. It was getting to be easier. I'd probably shrunk my stomach by then, and it just wasn't an effort not to eat.

It was more of an effort and a problem after I had eaten, because I was really starting to feel guilty. I remember we got our Christmas picture taken, and then we all went out to eat. I refused to eat anything. That was the first time that I had shown that I wasn't going to eat in front of my brothers and sisters. This was when my brothers and sisters became aware. And when we got the pictures back, my mom wouldn't even send them out, because I was really looking thin.

*ML*: Tell me about going to the hospital.

*V*: The day before I went to the hospital I came home around 4 o'clock and my mom and dad were home. They didn't even say anything to me. But I knew something was wrong because they are never home this early. And so finally that night I said, "Why are you guys home? What's happening?" And my mom and dad said, "Well, we've decided we're going to take you to the hospital tomorrow." And for an inane reason, God knows why, I was so mad, but I didn't say one thing. I just said, "Oh, okay." I was really mad, but I think inside I knew that something was wrong. Another thing, I kind of felt it might, you know, just be fun to go to a hospital for a day and then be back to the normal things.

The next day we went to the hospital and I just knew something was going to be crazy about this place, because the lady that admitted you was the weirdest-looking thing I'd ever seen. I just got scared—I didn't know—when they said a hospital, I was thinking a normal hospital—I never even thought of a psychiatric hospital. I didn't know what one was. And the doctors were just asking me everything, in front of my mom and dad, just like I was crazy or something, and I didn't know what was happening. By this time I was starting to cry,

because I wanted to get out of this place. I was on an adult suicide and depression unit, because they didn't feel I'd fit in with the teenagers and their drugs and stuff like that. In effect I was kind of a goody—I had always been—well, I had just not been a problem at home ever.

Finally, my dad said, "The best thing for us to do is just go. We'll come back and see you or call you in a few days." So I started running after my mother, crying, and then they went through the doors, and I'll never forget—I just stood there sobbing away, through this door, and my mom's trying to reach through the door, trying to go for me, and my dad's telling her, "No, you're not going back."

*ML*: At this point did the doctors or nurses or anyone tell you why you were there? Did anyone say anything about how thin you were?

*V*: Well, they said, you know, "You're skinny." But in my head I was thinking, "I want to lose more weight". . . .

*ML*: Did anyone mention "anorexia nervosa"?

*V*: No, I'd never even heard of the word up to that point. So I go to dinner with the other patients, but I wouldn't eat anything because I hadn't run that day and I was very mad about that. The next day I get up, and they do all this testing and took blood and weighed me; I was losing weight still because I wasn't eating.

*ML*: How tall were you and how much did you weigh at this point?

*V*: I was still 5'4" and around 85 pounds.

*ML*: When you looked in the mirror and saw yourself without any clothes on, what did you think?

*V*: I didn't stand in front of the mirror naked like everyone always asks me, but I used to stand in front of the mirror and I thought I looked normal. I'd look at myself naked but I didn't stand in front of the mirror, and I just thought I was normal. I liked my hipbones sticking out, and I liked it that when I laid

flat my stomach would sink down. I just liked it—it was attractive to me.

*ML:* Tell me about your first few days in the hospital.

*V*: By the third day I was still losing weight—I was down around 80 pounds. So they started this thing where you have to gain one-fourth of a pound a day or stay in bed. And I was like, "Okay, right, you can't make me do this." So the next day I kept losing weight and I ended up staying in bed. So I had to stay in bed until I gained weight. Then it started to be really weird—it was like a cycle—I'd gain, and then I would lose, and I would be in bed, and then I'd gain, and then I would lose. I was supposed to be going to school, but when I didn't gain my weight I had to stay in bed all day. So I started not caring, because I didn't want to go to school anyway.

*ML:* Were there other anorexic girls or boys there?

*V*: Yes, this was the first time I had come in contact with other girls with anorexia. There was a ballerina girl and this other girl from the adolescent ward. I was really jealous of them, because one of them was really thin, and she had been in the paper for—I don't know why—she was not really famous, but she had some notice about her because she had been in another hospital. She had been like a gifted ballerina and gotten so thin and everything that she was written up about.

*ML:* Did they look very thin to you? Did you see *them* as being too thin?

*V*: I thought they were ugly, but I liked that they were thin, although it made me jealous because I thought they were thinner than me.

*ML:* Was the staff letting you exercise?

*V*: No. So when I was in bed I would get up to go to the bathroom, but I would go in the bathroom and exercise. Well, they caught on to that pretty quick, and then they started taking me to the bathroom and all this kind of junk. Then I realized that I got weighed every morning at 6 o'clock. So I'd get up at

4:30 A.M. and weigh myself. If I was okay [in her eyes], I'd go back to bed. If I wasn't, I started drinking almost a gallon—I mean I could drink so much that I could gain almost five or ten pounds like that. So it just became a little game there.

*ML*: This is going to sound like a strange question, but how did you feel about the food? Were you afraid of it?

*V*: I hated it. I wrote poems and stuff about calories and how much I hated them. I hated it so bad, but I was so hungry it tasted good and it was the first time I ate these kind of things. They brought me like starch galore—doughnuts and powdered eggs and bread and everything—and I ate it, because I wanted to be out of bed. But then after I ate it, I just hated myself so much.

*ML*: Why did you hate yourself?

*V*: Because I felt fat. I felt like the food was just fat and that was it.

*ML*: Did you feel like you were losing control when you ate?

*V*: Yeah, but I had never thought of the word "control." I just thought of it as like losing a power. . . .Yeah, I loved it when I didn't eat. I just thought it was great. I just felt so strong and everything. I didn't want to start eating and changing how I was. Because I had conquered hunger. . . .

## The Parents

*ML*: When did you first become aware that your daughter had a problem?

*Mom*: She was 13 years old and had just finished eighth grade. That summer she had some disappointments. She had tried out for cheerleading two or three times and had not made it, and the ninth grade tryout was the final time. Her very best friend at that time had also tried out for it and made it. The

night her friend made it, we were feeling badly for our daughter because she hadn't made it and we went to a pizza place, and as we were there, the girl walked in and just literally ignored her.

*Dad*: Her other cheerleader friends cut her like she didn't even live, the kind of stuff I thought only happened in movies.

*Mom*: Along with that, she seemed to be having problems with her peer group. She'd go to the pool and there were girls there that literally wanted to fight, physically. A couple of them followed her home and threatened to hit her because she was trying to be so prim and proper and so forth, and they were going to show her.

That summer she flew back East by herself to spend a couple of weeks with her grandparents. We came out early to meet her, and she seemed very different. I knew she was lonesome, but she had her family and grandparents there, so I couldn't understand why she was acting so differently than I'd ever seen her act. When we got there she was very conscious of what she was eating and of exercise.

Also she wanted everything planned. She'd wake up and say, "What are we going to have for dinner tonight? What are we going to do today? Let's have the day planned."

*ML*: Was this need to have things planned present before the vacation?

*Mom*: Yes. As we look back, we see some of the indications, but we didn't notice them at the time. At our previous house we had shag carpeting. If anybody was lying on the floor, she'd go in and "rake" it every time.

*Dad*: That took place a year or so before, this great desire for even striations, even carpeting. If someone would walk across it, she'd get furious. But it wasn't serious enough to pay any attention to at the time.

In retrospect we have never been able to determine—and I mentioned this to the counselors at the hospital—any great traumatic event that occurred during that time.

*Mom*: When we got home from the vacation, her personality change became—within a month it was unbelievable. Here was a kid who was happy before. . . .

*Dad*: She was starting to become a bug on exercise.

*Mom*: And things had to be in order. She didn't like to have anything out of order. If I put anything down on my desk and went away for five minutes, when I came back it was gone. This became unbelievable later, so that I would just get furious and say, "If you touch my things when I put them down, I'm going to break your arm, because I want my glass there when I come back." But we didn't pay a whole lot of attention to all these things, because I thought, "Oh well, it's just one of those things." But my husband said to me, "I think she wants to do this cleaning bit too much. I really think that we should try to curb her. . . ."

*Dad*: It was turning into an obsession—she was constantly running around with a vacuum cleaner—that sort of thing. It wasn't natural for a teenage kid—I got tired of it all. . . .

Then when she got back to school—she was one of the few freshmen who made the varsity soccer team. This made it reasonable that she would be interested in jogging, but then she really started to jog. She still looked good, but the exercise was continuing, and one of the first outside clues that something was wrong physically came from the soccer coach. After our daughter had been on the team a month, she got hit in the head by a ball. When we came over, the coach said she was concerned, because our daughter was becoming lethargic. The coach said, "We don't know, we think there's something wrong with her—the hit in the head, for instance, shouldn't have had that effect."

And she wasn't happy at school, although she used to love school. When things began to happen, there was this tremendous nostalgia for the city we used to live in, where she was popular as the devil, where she had girlfriends that were close and all that.

*Mom*: In October she was losing weight and she was sneaking food around, and she was planning all this to avoid us noticing that she wasn't eating.

*ML*: Can you tell me what mealtimes were like?

*Mom*: Dreadful.

*ML*: Can you describe one?

*Mom*: She would become sullen, and not want to talk to us about anything. We were trying to bring her out, we were trying to reason with her, but occasionally we got mad at her, and she'd get up from the table and put her plate off to the side. She was not very pleasant to be around.

*Dad*: She got more and more overtly nasty to her mother, but she'd always temper herself because I wouldn't stand for kids acting like that with me.

*ML*: Did you comment on her weight and food and matters of that sort at the dinner table?

*Mom*: No, not at the dinner table. I remembered the interaction of the parents with this young girl in an after-school television program on anorexia nervosa, and so one of the things that I really tried to avoid was dwelling on food.

*Dad*: In fact, dinners were horrible, filled with reproaches, and my wife and I would sit there with our stomachs like this. . . . And we'd watch her fiddle around, and we'd say, "Aren't you going to eat anything?" And some nights I'd get up and throw her plate, I'd get so damned mad. We couldn't eat. I'd get so upset because the kid is literally starving herself in front of us.

And we knew we couldn't force her to eat. This is what gave us—gave me—the combination of complete frustration and upset, fear, and complete anger—this ambivalence—toward this willful, damned brat. . . . On the other side, here's my baby, starving to death. And it was horrible. It was hellish.

*ML*: Did the term "anorexia nervosa" come up at all at that point?

*Mom*: Yes it did. One day I had come home from

work early and she was particularly mad. We were talking and I said, "Does the way you're eating remind you of anything we have seen together?" And she said, "What do you mean?" And I said, "Well, just some of the interactions and the way this is evolving make me think of the program we saw together about this girl who was anorexic and was in the hospital and wouldn't eat, and the way her parents tried to force her to eat." And she said, "Yeah?" And I said, "Well, do you feel that you have anything that's like that at all?" And she said, "I don't know. Do you think so?" And I said, "Well, I don't know, because I don't really know what you're trying to do. For one thing, I know that you're losing weight and you're not kidding me. And I don't know if you're trying to kid yourself or what the story is." Then she said, "Well, it's none of your business."

As time went on, she would really blow up at me. Here's a kid who never had words with me. And going through the younger years and very early stages of 10 and 11 and 12 and all that—it was a breeze.

*ML*: Were those fights and blowups always about food?

*Mom*: No, they weren't necessarily about food at all. It would be just about anything that happened. We could not agree on anything. And at one point, when she was really getting to me, I finally realized she resented that I was gone and that I was working. It came out very vividly that I had stayed home for 23 years but I couldn't stay home for her.

*ML*: Tell me about the decision to see a doctor.

*Mom*: At first there were so many little things that were said, but they weren't important enough to really pay attention to them. But when they finally began to add up, I decided that I wasn't going to fool around with a family doctor that didn't have any idea about this at all. My daughter-in-law's neighbor was a nurse at a local hospital—and they had a very good friend whose daughter was anorexic at age 14—and she brought a book over for me to read. . . .

*ML*: Can you recall the title?

*Mom*: It was *The Golden Cage* [by Hilde Bruch. Cambridge: Harvard University Press, 1978]. I scanned enough of it in an evening to decide to call the nurse and get the name of a doctor who would be able to recognize anorexia nervosa. I got the name and made an appointment. She was then about 5'5" and 95 pounds.

She was furious at me for taking her. Her personality was changing. . . . This kid had never had a spanking in her life. You don't have to spank a kid who never does anything wrong. She was a perfectly terrific kid.

*Dad*: What made this very hard for us to accept was that the four older children—our daughter is the youngest by almost five years—had literally gone from the same womb through the same procedures. We hadn't made any radical changes in discipline and so forth. All four graduated from college. I'll also say right up to that time we were quite self-congratulatory about this, and I'm sure were even rather intolerant of other people who hadn't raised their kids as well. Along comes this obstreperous kid, and she caused this big trauma of fright and anger and—what the hell's the matter with this kid?

*ML*: Could you describe some of these personality changes?

*Mom*: She became angry at everything that was said to her. She cut off her friends, she didn't want to have anything to do with them. She had decided at that point that people here were not like her friends in the town where we used to live. She said, "They all have to have sex, they drink, they smoke, and none of my old friends are doing that." You know, we had the regular talks: "Now, you've got to recognize that everyone is changing at this age. Your friends are changing too. And hopefully they're not drinking and smoking and having sex. . . ."

*Dad*: She was putting herself on the outside, that was clear.

*Mom*: Right. And she was saying, "This is all wrong.

I'm not going to have anything to do with any of them because they're all doing this." And so one by one, she was eliminating her friends. She was also running eight miles a day *after* going to soccer practice.

*ML*: What was happening in school at this time?

*Dad*: Very antisocial behavior. No friends and she was miserable.

*ML*: Did she have any trouble with her schoolwork?

*Dad*: No, she could keep her marks in decent shape, although there was no question she wasn't able to maintain concentration.

*ML*: Was she upset about her studies?

*Mom*: Oh yes, she did become obsessive about her studies. At a later point she did. She would have to get all her homework done, and her typing teacher told me, "I have never had a student who wants to go through every book, and do absolutely everything and be ahead of everyone else."

*Dad*: But it was more rote mechanical memory, almost a try to grasp it and squeeze it all in. But she was almost correspondingly ineffective in math and subjects where she had to think, where her mind was free. . . .

*Mom*: The counselor called me and she said one of the classroom teachers had noticed that our daughter was very tired. Of course, she was dropping weight more rapidly as time went on, and she was getting very sullen and resentful. She was losing all this weight, she was doing all this exercise, all this running, and she was exhausted.

*ML*: Was she still playing soccer at this point?

*Dad*: She had lost interest by then. She thought they were a bunch of jerks. She just didn't give a damn about anyone. There were a couple of times that really depressed me. She was lying up on her bed and she was raving. . . .

*Mom*: Screaming and crying. . . .

*Dad*: . . . and I thought, "She's crazy." . . .

*ML*: It sounds like things had deteriorated almost completely by the time you were getting ready to go back to see the doctor. Was she purging or using diuretics or laxatives or anything like that?

*Mom*: No, no. Well, she did tell her sister-in-law that, after we had been out for a huge brunch, she said she felt "horrible" and "hated herself" and then she went out and bought laxatives. After she took them, she got really sick; she got weak and she almost passed out. She didn't tell us that, but she told her sister-in-law, who said, "Well, that's going to happen. You could get sick and you could pass out taking those. It's very, very dangerous." And she was still young enough that those things scared her, and I think she probably tried to purge a couple of times, but that also scared her.

*ML*: Tell me about the period right before she was hospitalized.

*Mom*: When we went to the doctor for the second time, a week later, she was down from 95 to 90 pounds. She told him what she ate and he said, "I don't understand how you're down to 90 pounds if you've eaten what you said you've eaten." And she said, "How do you know your scale's right?" And he said, "Well, I'm quite sure my scale is right." But she was so very sullen and said, "I do just what I please."

Then she went outside and he told us, "I very definitely feel that you have a real problem. I would suggest that you seek out a psychiatrist or psychologist, whichever." After we asked, he recommended someone at a nearby university. I tried for about three days to get hold of this person, but when I finally did, he said, "I can't see you for about a week."

By this time things were getting worse and worse daily. And she was saying things to me like, "I'm going to kill myself. I'm either going to starve myself to death or I'm going to go over the nearby dam." She had me scared. And she was saying all of this to me and avoiding saying any of it in front of her dad. She was nasty but she wouldn't

tell him anything.

First of all, I thought I was overreacting—and my husband thought I was overreacting at first—but then I called the doctor at the university back. When I told him what she said, he said, "You're not overreacting. Get her in the hospital."

*Dad*: The day that it actually came to pass—it was November—I was standing out in the garage, and I see it pouring rain, and for maybe the second or third time that day, there's our daughter, running in the rain, up and around the circle, and she comes around and keeps right on going. I went back in the house and I said, "There's something terribly wrong with this kid; she's sick and we've got to do something."

*ML*: It must have been frightening.

*Dad*: Scared the hell out of me.

*ML*: What happened when you told your daughter you were taking her to the hospital?

*Mom*: Well, after she was through running in the rain, she came in and we told her. She cried and was upset and said she'd be fine. But the next morning we took her to the hospital—that was an experience beyond belief. When we took her into the ward and finally did leave her, she was literally pulling at me and dragging at me, "Mom, don't leave me, don't leave me. . . ."

*Dad*: A locked psychiatric ward.

*ML*: This was not an eating disorders unit?

*Mom*: No, they thought she was better off to stay in an adult psychiatric unit than to go into the adolescent unit where they were having drug problems and drinking problems. But the adult unit was scary.

Later she would scream at me on the telephone, and call me everything under the sun, if I didn't do exactly what she wanted me to do. I was just torn apart, because you can't keep tearing into her. I'd go down there every single night . . . and if she couldn't manipulate me totally from the time I'd arrive, then later she'd get me, you know, she'd keep

me on the telephone, she'd scream and holler at me. She'd tell me this was a crazy place I'd put her in, and why was I doing this to her, because there was nothing wrong with her, and there was something wrong with all the rest of us.

*ML*: How much did she weigh the day she went into the hospital?

*Dad*: She was 5'5" and she weighed about 80 pounds.

*ML*: Looking back on it now, how would you describe what you went through emotionally?

*Mom*: Much later, in support group we finally did see a pattern. We were there for several evenings and maybe several weeks and, the next thing you know, someone else there would come who was at the same stage that we had been five weeks before that, and they were going through the same feelings . . . the sadness. . . .

*Dad*: No, I think you start off with, if not bewilderment, surprise: when you first come home from the hospital, you're almost thunderstruck by the implication that you've got a mentally ill child. Depending on your personality, what's really happening underneath is that you're scared silly and upset and frustrated at the insidious nature of it. The real frustration of the thing is that, on the one hand, you're terribly upset and worried, because this kid is in a life-threatening position. On the other side, the one who is doing this to you is creating more damage to you than anyone else you know could, because you could shut others off or fight or defend against them. So there's the combination of almost hate at times toward this child for the pain she's bringing—you've got this damned mixture of complete upset, sympathy, affection, and so forth—and at the same time, there's real enmity for the same person who's doing this uniquely to you. How do you defend against someone in whom the threat exists as well?

You may cover this mixture up—my wife's way is to be upset and I suppose the way I handle fear is anger. The culture doesn't allow me to

cry and carry on, so I get into a fighting mode, but who the hell can I fight? My wife, the woman I work with, whom I'm closest to, I fight with her and so forth—you're upset all the time, and it's got to come out somewhere. . . .

Then gradually there's kind of a resignation. This is also insidious in that the resignation, I think, is admission of the fact that there's a real complete and permanent depressed feeling. Even now I find it difficult to forgive my daughter for what she's done to us. Even though intellectually I understand it, it's another thing to feel it emotionally. I have a hostility toward my daughter. I can't help it, even though I understand it, because none of my other four children ever did to their mother or to me what she has. It's pretty darn close to the surface, there's no question, because some of her stupid selfish habits will trigger it.

But then there's also a little bit of pleasure and happiness—you feel good when she's beginning to make progress and her weight's coming back—now she's in budding health again, she looks good, and in that sense we feel good. But the permanent residue of this for me, and I think for our daughter too, is that we are much more . . . "calloused" is too strong a word and "tough" doesn't do it. . . . I have a lot more latent suspicion of her motives, I have a lot more permanent feeling of, here comes that crap again. I honestly wish I were more rid of that, but I'm not.

*Mom*: My feelings are not as strong as my husband's. My feelings are much more tempered as I go along, and I do not think I have the feeling of leftover resentment. I'm so pleased that she has come along as well as she has. I am so thankful that I almost feel maybe I better feel happy and pleased about it. After all these years that we worked so hard to help her, we've got to feel good about it.

* * * *

*Epilogue*: This transcript is the introduction to an interview that runs four hours and nearly 90 typewritten pages. The daughter's anorexia nervosa began when she was 13. Her parents have been through a great deal, and they have given a great deal in family therapy, in support groups, in volunteer work for an eating disorders association, and in a continuing commitment to their daughter.

Vicki is currently 18 years old and living at home. She was released from the hospital in December of her thirteenth year, but rehospitalized the day before her fourteenth birthday in mid-January when her weight plummeted below 80 pounds. At one point following her final hospitalization she began binge-eating a certain diet snack food to the extent that her parents became the second largest bulk purchasers of that food in the state. She was also apprehended several times for shoplifting food, even though she had plenty of money with which to make a purchase. She barely managed to graduate from high school, principally because her egocentric refusal to participate in the school routine and her hyperactive involvement in working three jobs led her to miss too many classes. She has never had a menstrual period, and she continues to hold down several jobs as a waitress and to exercise a great deal, if not ritualistically. Her father is very concerned about what he perceives as her need to keep moving, to keep active so as not to think and feel too deeply about anything. Her mother is more concerned with her daughter's social and intellectual immaturity than with her activity level. All in all, however, their daughter is doing much better, thanks to an excellent hospital program, an expert on eating disorders to whom they were referred by a national eating disorders association, and her parents' love. At present her weight is up to 105 pounds and she is making a few friends. Her parents were elated about these small steps she is taking to recover when one night she called from an ice cream shop to say that she had stopped there for a snack.

CHAPTER 4

# Bulimia

8 P.M. Candy bar on the way out; I walked to the parking lot. Torn—so torn. Cold, wet from rain, and alone. Hmmm—[a restaurant] or stay here? Pace, pace, pace. [A restaurant] it was. Chili, BLT, grilled cheese, fries, milk. Threw up. Pretended I was waiting for Sally; must have asked the waitress four times if she had seen her. A girl asked me to join her and her friends. "Ahhh, I really must find my friend," I lied. Pretended to have called Sally, then I left. [Another restaurant]—sundae and parfait. Home; threw up.

9:30 P.M. So weak, numb.

11:45 P.M. A *diet* Squirt and here I am. I hope I lose weight; I hope I disintegrate.

—From the diary of a bulimic college student (Neuman and Halvorson [16, p. 44])

## General Definition

Bulimia ("ox hunger") is an eating disorder characterized by (7, 9, 16)—

1. Abnormal increases in hunger or in the need to eat despite the absence of subjectively experienced hunger.
2. Distinct and inconspicuous episodes of binge-eating, that is, "rapid ingestion of large quantities of food" in secret (9, p. 582).
3. Attempts to undo the effects of binge-eating by self-induced vomiting, restrictive dieting, excessive exercising, or use of laxatives, diuretics, and diet pills.
4. An inability to stop bingeing despite the perception that the urges, binges, and purges are unwanted and abnormal.

# Terminology

The following glossary may be helpful in sorting out the many ways in which "bulimia" or "bulimic" is used (2, 9):

BULIMIC ANOREXIA:
As discussed in Chapter 2, meets the criteria for anorexia nervosa and bulimia simultaneously.

BULIMIA NERVOSA:
Meets the criteria for bulimia, and purges with self-induced vomiting and/or laxatives/diuretics. Was formerly anorexic or extremely thin, but is currently within the normal range of weight-for-height.

NORMAL-WEIGHT BULIMIA:
Meets the criteria for bulimia but was not formerly anorexic or very thin. May have been formerly overweight, but is currently within the normal range of weight-for-height.*

BULIMAREXIA:
Identical to bulimia nervosa, except the person need not have been anorexic or very thin. Bingeing and purging occur together along with several psychological aspects of anorexia nervosa: preoccupation with food and body size, perfectionism, social withdrawal, and low self-esteem (3).

BULIMIC BEHAVIOR:
Extreme hunger and/or binge-eating that are either pleasurable ("pigging out") or attributable to some organic cause (such as brain tumor, discontinuance of anti-depressant medication). This should be considered disordered eating, not an eating disorder.

*Virtually nothing has been published about the overweight bulimic. Such people exist certainly, but it is very important to distinguish between bulimia and obesity as defined in terms of excess weight-for-height. As discussed in Chapter 7, it is a myth that overweight people are compulsive or out-of-control eaters.

The overlap in labels and definitions for the various types of bulimia can be confusing. Fortunately, recent research by Garner and Garfinkel suggests that distinctions based on current or past weight may well be moot (9). They found that normal-weight bulimics differed from restricting anorexics along the same dimensions as did bulimic anorexics (see Chapter 2, p. 50, and Table 4–2). This research confirmed Garner and Garfinkel's "clinical impression that the symptom of bulimia, whether it occurs in anorexia nervosa or in patients without a history of emaciation, is very often associated with similar clinical features that can be distinguished from those found in patients with the restricting subtype of anorexia nervosa" (9, pp. 581-82). In the future, the various bulimic syndromes—bulimia nervosa, normal-weight bulimia, and bulimarexia—will be known as *bulimia nervosa* (see the Introduction of this book).

## Natural History

Before considering the individual features of bulimia, it is helpful to think about this eating disorder as the outcome of a process that encompasses many normal or at least common aspects of growing up (7, 16; see Chapter 9 for a full consideration of the causes of bulimia).

Bulimia usually begins between ages 15 and 20 (7, 15), although before this time many bulimics have problems with eating habits or weight: anorexia nervosa, childhood obesity, adolescent weight in the high-normal range, or lifelong fluctuations in weight. In many cases bulimia begins with the institution of a diet following a distressing life event (the breakup of a romance), a challenge (making the gymnastics team), or any situation that encourages the person to think about body shape and its links with control, popularity, and achievement. It is probably not coincidental that the peak age of onset for bulimia—16 to 18—is a time of transition from high school to college, from high school to married life, from the family to independent living.

Restrictive dieting usually results in weight loss, and as such it is often encouraged by family, friends, and our culture (see Chapter 7). The Minnesota starvation study (see Chapter 2) has demonstrated, however, that this type of deficient diet produces a preoccupation with food, a tendency to binge-eat, and emotional instability. At some point a minor indulgence or a major disappointment catalyzes these effects of self-starvation into a binge-eating episode.

The initial episodes of overeating are experienced as both pleasurable and horrifying. This mixture simultaneously intensifies the need to diet and increases the probability that a binge will again be used to relieve the mounting urge to overeat that dieting creates. Harassed by this impasse, many bulimics discover self-induced vomiting, and the trap is sprung.

During the first year of bingeing and purging, the bulimic tends to lose weight. This loss produces an increase in starvation-induced hunger and the illusion of having stumbled onto a way to binge and reduce. Consequently, over time the frequency of bingeing increases, the amount eaten during each episode rises, and the frequency and severity of purging follows suit.

Approximately one-third of the calories taken in during a binge are retained after a purge; therefore, increased bingeing means that more and more calories are absorbed. Eventually, weight begins to rise rapidly, causing the frightened bulimic to intensify her efforts to reduce. This leads to irritability and hunger, the precipitants of a binge. Through repeated association with temporary tension reduction, bingeing becomes a habitual response to any form of discomfort, including boredom. Paradoxically, this loss of control over bingeing makes it a source of tension in its own right. This means that in the later stages of the disorder purging comes to play a bigger and bigger role in alleviating distress.

Strange as it may sound, many long-term bulimics are locked in a cycle of bingeing to purge and purging to binge. For them, bingeing and

purging are no longer spontaneous reactions to disappointment or indulgence. They are daily and carefully orchestrated events that "consume" the bulimic's time, money, energy, and sense of involvement in the world.

The progression from dieting to daily binge-purge cycles usually unfolds in secret over a long period of time. The role that school staff and students can play in detecting and preventing bulimia is highlighted by the sad fact that, while the average age of onset is 17 or so, the average age at which individuals seek therapy is 24 (7).

## Central Features

The course of the disorder makes it clear that "bulimia" (bulimia nervosa) refers to a multifaceted disorder in which binge-eating is but one of a number of features (see Table 4–1). The following sections present the major characteristics and commonly associated features described by a number of experts (1, 2, 7, 12, 15, 16, 17). It is important to note that this information is based primarily on investigations of "white single women in their early 20s who had at least some college education" (7, p. 6). Research with high school students has begun (see Chapter 6), but much more investigation is needed to develop an accurate profile of bulimia in this group.

### Recurrent Episodes of Uncontrollable Overeating

#### *Type of Food Eaten*

Discrete episodes of uncontrollable overeating are called "binges." They usually take place in secret and last anywhere from 30 minutes to eight hours. During that period, the individual may consume an unbelievable amount of food—a quart of ice cream, a box of cookies, a dozen doughnuts, a bag of potato chips, and a half gallon of milk. The

Table 4-1. Central Features and Commonly Associated Characteristics of Bulimia

CENTRAL FEATURES

1. Recurrent episodes of uncontrollable overeating
2. Efforts to undo the effects of binge-eating by self-induced vomiting, severe caloric restriction (abusive dieting), excessive exercising, use of legal or illegal appetite suppressants, and/or use of laxatives or diuretics
3. Chronic anxiety, guilt, depression, and tension

COMMONLY ASSOCIATED CHARACTERISTICS

1. Drastic weight fluctuation[a]
2. Impulsivity and emotional instability
3. Acting-out via substance abuse, theft, self-multilation, and/or promiscuity
4. Problems with social adjustment
5. Depression
6. A high need to achieve in order to obtain the approval of others

[a]When body weight drops to a low level, the effects of starvation (see Chapter 2) become important aspects of bulimia.

bulimic usually binges on food considered off-limits or "bad" by dieters, such as ready-to-eat junk food and other fattening items that can be devoured with little preparation. Not all bulimics eat a huge amount, however, and some binge-eat fruit, vegetables, and other foods that would constitute a regular meal. Whatever the type of food consumed, it is gobbled rapidly with little or no appreciation of taste or other characteristics. In this respect, some bulimics (see Chapter 5) may even eat raw bacon or dough.

### *Amount of Food Eaten*

Based on the literature, the amount eaten during a single binge ranges from 1,000 to 55,000 calories, with an average of approximately

4,000. But, as noted above, not all bulimics eat a tremendous amount of food during a binge. This has led some experts to argue that the defining feature of a "bulimic binge" is the uncontrollable and compulsive nature of the consumption in conjunction with the use of vomiting, laxatives, diuretics, diet pills, and/or fasting to undo the physical and psychological effects of gorging. In general, bulimics who eat a tremendous amount of food are more severely disturbed in terms of dangerous purging practices, significant weight fluctuations, and a more disorganized life in which extreme psychological distress is frequent.

### *Timing*

Sometimes the binge is a spontaneous reaction to an upsetting life event. Other times the trigger is hunger, boredom, or indulgence in a small, seemingly harmless amount of forbidden food. After the disorder becomes entrenched, the binges may be carefully planned: time is set aside and jealously guarded; food is shopped for or stolen and then hoarded; and the binge itself is carried out in a ritualized manner. Most binges occur around mealtimes, particularly in the late afternoon after school or work.

### *Feelings*

The emotions surrounding a bulimic binge are very different from those attached to a regular meal. Whether or not it is planned, the episode usually begins with feelings of tension, boredom, and stress. Immediately before gorging, the bulimic feels irritable, helpless, and depersonalized, the prisoner of an overwhelming need, not just to eat, but to eat those foods that are forbidden at other times. The initial effect of indulgence is relief from unbearable tension. As the binge proceeds, however, tension is restored in the form of anger, guilt, shame, and anxiety over discovery.

### *Termination*

Episodes of binge-eating are terminated by lack of sufficient supplies, sleep, social interruption, intense anxiety, or acute pain. In well over half the cases the psychological and physical distress is relieved by self-induced vomiting.

The emotions following termination of the binge are a mixture of relief, anxiety, and depression. The feeling of relief tends to be greater for those who induce vomiting. This is very significant. To a large extent the power of vomiting and bingeing to relieve the tension created by each other and by life stress is the basis for the bulimic's loss of control over eating.

### *Frequency*

For an individual to be considered "bulimic," his or her binge-eating must be "recurrent." That is, it must occur with sufficient frequency to constitute a pattern or habit. The reported frequency of binge episodes for those who meet the other criteria for bulimia ranges from weekly to six times per day, with an average of one to two episodes per day (15). The average and range are useful statistics, but they should not be used as a criterion. If binge-eating (and purging) constitutes a pattern—whatever the frequency—that meets the IMAD criteria, then that person is bulimic.

## Efforts to Undo Effects of a Binge

A binge has a number of troubling effects that the bulimic may attempt to reverse. The most immediate ones are physical discomfort caused by stomach distension, and depression or shame caused by a complete loss of control. The less immediate, but potentially more terrifying, effect is the joint prospect of weight gain and (in the bulimic's mind) public exposure as a fat, worthless, out-of-control binge-eater. This constellation of negative

consequences makes it easy to understand why at least half of all binge-eaters ultimately resort to various methods of purging that they believe will magically undo the effects of the binge. Purging is not considered absolutely necessary for the diagnosis of bulimia (7), but it occurs with sufficient frequency to be considered a major feature.

### *Self-Induced Vomiting*

Most people associate vomiting with the retching caused by illness or drunkenness. Consequently, they find it difficult to understand how anyone could willingly induce it, especially on a regular basis. This is reasonable bewilderment, but it overlooks two important facts. First, the motivation to purge is very high. Second, escape artists and drug smugglers have demonstrated repeatedly that vomiting is a reflex that can be mastered and converted into a skill.

With practice many bulimics develop this same skill. They too hate the uncontrollable nausea of the flu or intoxication. Thus, they learn "a highly controlled, almost ritualistic regurgitation that is experienced as a restoration of control, a relief from pain, and/or an expression of disgust and anger" (14, p. 30; see Chapter 9 of this book). Some bulimics induce vomiting by inserting fingers or an object such as a toothbrush into the throat. Others learn to control the vomiting reflex by contracting their stomach and chest muscles. Still others resort to potentially lethal emetics such as syrup of ipecac (see Chapter 2, p. 55).

Self-induced vomiting is an illusory form of control. It does not prevent absorption of a significant amount of calories. Moreover, it interferes with the body's normal satiety mechanisms in a way that makes binge-eating even more uncontrollable (22). But most important is a point made earlier: the transitory weight loss that most bulimics enjoy after they begin vomiting reinforces their misguided hope that purging is a magical way of having their cake and not having it too. It is not. In fact, self-

induced vomiting is a dangerous and generally ineffective form of weight control that stimulates hunger and thereby increases the frequency and rapaciousness of binge-eating.

### *Abusive Dieting*

Bulimics, like anorexics, have a strong drive for thinness and an irrational fear of becoming fat (9). So it is not surprising that a binge or series of binges leaves them very anxious about the prospect of weight gain. To "reduce" this anxiety, many bulimics resort to one or more unhealthy dieting strategies: prolonged fasting, skipping one or more meals each day, eating only several hundred calories at each meal, omitting all carbohydrates, and using legal appetite suppressants or illegal amphetamines. In their minds these tactics compensate for excess intake during a binge, while enabling them to do penance for being "bad."

The need to be thin makes bulimics very sensitive to minor, normal fluctuations in their weight or in the fit of their clothes. Moreover, although many bulimics are handsome, attractive people, a significant number overestimate and loathe their body size in the same distorted fashion as anorexics. These distorted attitudes and perceptions are an important aspect of the psychology of bulimia. They make it likely that not just a binge, but any "feeling" of heaviness that raises the spectre of becoming "fat" will trigger anxiety and abusive dieting. Unlike the restricting anorexic, however, the bulimic's intense fear that she will lose control, "blow it completely," and become fat is based on actual and painful experiences with binges and concomitant weight gains.

Abusive dieting may temporarily compensate for binge-eating. But severe dieting is a form of semistarvation and will eventually result in an obsession with food and a stronger tendency to binge-eat. Thus, the experience of the bulimic coincides with that of the anorexic in affirming that dieting makes it *more* difficult to regulate hunger.

### *Laxatives and Diuretics*

Many bulimics believe that they can eliminate excess food and guard against the possibility of weight gain by using laxatives, diuretics, or enemas to purge themselves. This is simply not true:

> Besides being extremely dangerous, laxatives are a completely ineffective method of trying to prevent the absorption of Calories. Laxatives primarily affect the emptying of the large intestine, which occurs *after* Calories from foodstuff have already been absorbed in the small bowel. A recent study of both bulimic and normal women documented that even extremely large dosages of laxatives do little to impair caloric absorption. . . . One patient consumed 50 Correctol tablets after her meals; although it produced tremendous diarrhea (over 6 L or 6.3 qt.), the caloric absorption was only decreased by 12%. This amounts to less than 200 Calories, which is the equivalent of one small candy bar! (10, p. 542)

Approximately 25 to 30 percent of post-high school bulimics use laxatives on a weekly basis (12), while the corresponding figure for high school students is about 10 percent of those with bulimia (see Chapter 6). Laxatives tend to be used immediately after a binge, and the number ingested varies from several to handfuls. Most laxative users also engage in self-induced vomiting.

Many people mistakenly believe that diuretics can reduce body fat. In fact, they are completely worthless in this respect (10). Fortunately, weekly use of diuretics is rare in high school students, although it occurs in more than 10 to 20 percent of college-age and older bulimics.

## Anxiety, Guilt, and Depression

Unlike most restricting anorexics, bulimics understand that they have an eating disorder. Their binge-purge cycles, interspersed with perpetual bouts of weight gain and dieting, make them feel disgusted, powerless, and useless. These negative feelings do not terminate the process, however,

because it is sustained by tremendous anxiety. "What will happen if I stop dieting? Will I lose control and blow it? Will I be able to eat (binge) when I blow it? How much will I eat this time? Will I be able to vomit afterward? What will it take to make up for the calories I couldn't throw up? A diet? What will happen if I stop dieting?"

Over time this circle of anxiety and guilt becomes encrusted with depression, shame, and chronic tension. At the center of this circle are bingeing and purging—the "terrible secret." The bulimic cannot tell people because it is shameful—she cannot tell people because they might deprive her of the opportunity to do these things—so painful but seemingly so necessary.

## Commonly Associated Characteristics

### Drastic Weight Fluctuations

Even though many bulimics appear to be well organized, bingeing, purging, and dieting create instability in a variety of forms. Drastic fluctuations in weight over the course of several months constitute one index of instability that may be readily apparent to those who see the person often. For example, if bingeing is frequent in January, the person's weight may climb from 115 to 130 during that month. Two months of asceticism then drop it to 110, only to have it climb back to 125 in the late spring when the hunger and stress created by self-denial renew habitual bingeing. These fluctuations may be as much as 35 pounds in either direction (7).

### Impulsivity and Emotional Instability

Another visible aspect of instability is impulsive behavior coupled with frequent emotional upheaval. Some of the bulimic's difficulty in control-

ling hunger is attributable to the sheer power of the urge to eat that the body generates in order to compensate for starvation. The bulimic's impulsivity with respect to food may, however, be a reflection of more general problems with impulse control and emotional instability (7, 9, 12, 13). Personality questionnaires reveal that bulimics have a low tolerance for frustration and a great deal of difficulty controlling their feelings, especially anger (see Chapter 9 for further discussion).

Behaviorally, impulsivity is manifested in a tendency to "act out" via drug and alcohol abuse, theft of food and other items, self-mutilation, and promiscuity (4, 9, 16). Bulimics are two to four times as likely to abuse alcohol and drugs as the general population. More specifically, a quarter to a third of all bulimics resort to alcohol as a means of coping with depression and chronic tension and as a method of delaying or preventing binge-eating (21). Not surprisingly, the combination of depression, impulsivity, and habitual substance abuse creates a high potential for serious suicide attempts.

## Problems with Social Adjustment

Bulimia also creates instability in interpersonal interactions. It is a disorder that is practiced in secret and polluted with guilt. The time, effort, and dishonesty involved, coupled with the need to eat and the emotional turmoil it creates, reduce the bulimic's effectiveness and bring her into recurrent conflict with others (12, 18). With family members there may be repeated arguments about food and other issues. At school trouble may arise over missed homework assignments or rebellious behavior in the classroom. Indeed, several studies suggest that long-term bulimia creates a persistent social maladjustment rivaling, if not exceeding, that of women who are alcoholic or schizophrenic (11, 18). This stark fact also emphasizes the importance of prevention and early detection.

### Depression

Virtually every bulimic patient has one or more of the following symptoms of depression: sadness and other negative feelings, an inability to derive pleasure from previously enjoyed activities (anhedonia), low self-esteem, pessimism, guilt, feelings of alienation and isolation, fatigue, insomnia, and disturbances in the ability to concentrate (6, 12, 20). The relationship between bulimia and depression is discussed in detail in Chapter 9.

### Perfectionism and the Need for Approval

A significant number of bulimics have a very high need to achieve in order to obtain the approval of others. They erroneously believe that such success will be attained only by firm adherence to inflexible distinctions between "good" versus "bad" behavior (3, 7, 17). Between binge-purge episodes these bulimics demand perfection of themselves with respect to studying, exercising, fashionable attire, proper behavior, and, of course, dieting. As yet another irony, these rigid and unrealistic attempts at self-control only serve to increase the tension, hunger, and sense of failure that virtually guarantee further bingeing and purging.

## Pigging Out

The salient features of bulimia are binge-eating and purging. Consequently, this eating disorder is sometimes confused with a disquieting fad in high schools and colleges called "pigging out." Reminiscent of Roman orgies, this practice involves getting together with other students for the express purpose of marathon binge-eating, interspersed and concluding with self-induced vomiting (17).

This is a disturbing and unhealthy activity, but it is not bulimia or even an eating

"disorder" (see Chapter 1). In addition to binge-eating and purging, bulimia encompasses a number of significant features that distinguish it from hedonic overindulgence. These are (1) loss of control over eating, (2) guilt and shame, (3) a drive for thinness and an intense fear of becoming fat, and (4) secretiveness. Pigging out may cause transitory guilt (misery) and negatively affect health (inefficiency), but it is debatable (perhaps as a carefully thought-out class exercise) whether it meets the IMAD criteria for designation of a disorder.

This characterization is not meant in any way to condone pigging out. Binge-eating and vomiting may have very severe consequences for the digestive system and the teeth. Moreover, this "fad" teaches a person at risk for bulimia how to binge and purge, and then sanctions these activities with excitement and approval.

## Is Bulimia an Addiction to Food?

Many bulimics report that, as bulimia progresses, it takes on a life of its own. Given this experience, Overeaters Anonymous (OA) maintains that bulimia is an addiction to food that is identical in every respect to alcoholism (8).

Indeed, there are a number of striking similarities between bulimia and the criteria for addiction set forth by Dr. Stanton Peele, an authority on substance abuse cited by Neuman and Halvorson (17). Briefly, bulimic behavior results in the following:

1. Loss of voluntary control and of self-esteem
2. Suppression of both positive and negative feelings
3. Self-absorption and a narrowing of involvements
4. A commitment to tension-relief and a concomitant decrease in the ability to experience pleasure from other activities

5. Paradoxical security in the constancy of habitual but maladaptive behavior.

These characteristics, coupled with most people's misconception that overeating is the cause of obesity (see Chapter 7), make it tempting to accept OA's contention that bulimia is a lifelong illness of "compulsive overeating." A careful examination of this model, however, indicates that it is misguided (8). Putting together the findings of the Minnesota starvation study with the fact that so many bulimics develop their problems following professional advice to diet, Garner writes (8, p. 2):

> Food preoccupations, cravings, voracious appetite or the "drive" to eat in the absence of the subjective experience of hunger may be much more readily understood as a consequence of dieting and/or maintenance of a suboptimal weight rather than resulting from the abstruse concept of "food addiction" or "compulsive eating."

Bulimia is *not* a lifelong sickness characterized by a lack of will-power, a compulsive urge to overeat, and an inability to "handle" fattening foods (8). Bulimia is treatable; it can be cured. Moreover, the addiction model implies that bulimics must abstain from those foods on which they binge. To do so requires a "bulimic" categorization of foods into "good" (diet food) and "bad" (binge food), followed by the application of "will power" to abstention from the "bad" foods. This advice is potentially dangerous—it reinforces the bulimic's tendency to diet restrictively (in an anorexic fashion?) and to maintain weight at a semistarvation level (5, 8).

To overcome binge-eating and their preoccupation with food, bulimics need to balance their diet gradually so as to include, not exclude, reasonable amounts of sugar and carbohydrate. This normalization of diet ultimately decreases body weight in some bulimics and increases it in others (2). One of the goals of effective therapy for bulimia is to help the client accept the connections among regular consumption of balanced meals, attainment of a body weight that is *normal for her*, and improved physical and mental health (2, 10).

## What Is the Difference Between Anorexia Nervosa and Bulimia?

This is not nearly as important a question as it would seem to be. In many respects the numerous similarities (see Chapter 1) are much more significant for preventive education.

Nonetheless, research has revealed some consistent differences that may be of interest to students and that may facilitate discussion of why one person becomes anorexic, while another develops bulimia (see Chapters 8 and 9). These distinctions are listed in Table 4–2. Keep in mind that they are statistical generalizations subject to change as the few available studies are supplemented by further investigation.

## Teaching About Bulimia: Conclusions and Implications

### Definition

*Conclusion.* Bulimia refers to a class of eating disorders with three common features: (1) secretive and uncontrollable episodes of binge-eating, (2) unhealthy short- and long-term methods for ridding the body of unwanted calories and for controlling the unwanted urge to binge, and (3) a strong drive to become thin and an irrational fear of becoming fat.

*Implications.* Although discussions of bulimia necessarily begin with the definition of binge-eating, teachers should deemphasize the spectacular amounts that are sometimes consumed by bulimics and instead concentrate on their motives, their helplessness, and their dangerous self-control

## Table 4–2. A Comparison of Restricting Anorexia Nervosa and Bulimia

| RESTRICTING ANOREXIA NERVOSA | BULIMIA |
|---|---|
| *Clinical Features* | |
| 1. Refusal to maintain a minimum body weight for healthy functioning | 1. Same, plus normal, near-normal weight, or overweight |
| 2. Hunger and illness denied; often proud of weight management and more satisfied with body | 2. Intense hunger experienced and binge-purge considered abnormal; greater body dissatisfaction |
| 3. Vomiting less common (25 to 50%) | 3. Vomiting common (75 to 100%) |
| 4. Less antisocial behavior | 4. Greater tendency to antisocial behavior, e.g., alcohol abuse |
| 5. Amenorrhea of at least 3 months' duration common | 5. Irregular menstrual periods common; amenorrhea uncommon unless body weight is low |
| 6. Mistrust of others, particularly professionals | 6. More trusting of people who wish to help |
| *Common Personality Characteristics* | |
| 7. Tend to be introverted and obsessional | 7. Tend to be extroverted and dramatic |
| 8. Greater self-control, but emotionally over-controlled with problems experiencing and expressing feelings (alexithymia) | 8. More impulsivity and emotional instability |
| 9. More likely to be sexually immature and inexperienced | 9. More sexually experienced and sexually active |
| 10. Females are more likely to reject feminine role | 10. Females are more likely to embrace feminine role |

Table 4-2—*Continued*

*Course and Familial Factors*

| | |
|---|---|
| 11. Age of onset often around 13 to 15 | 11. Age of onset around 15 to 19 |
| 12. Greater tendency for maximum pre-illness weight to be near normal for age | 12. Greater tendency for maximum pre-illness weight to be slightly greater than normal |
| 13. Lesser familial disposition to obesity | 13. Greater familial predisposition to obesity |
| 14. Greater tendency toward pre-illness compliance with parents | 14. Greater tendency toward pre-illness conflict with parents |
| 15. Tendency to deny family conflict | 15. Tendency to perceive intense family conflict |

practices. This helps distinguish bulimia from overeating and pigging out. It also emphasizes the similarities between bulimia and anorexia nervosa, thus enabling students to apply the definition of an eating disorder (see Chapter 1).

## Bulimia and Body Weight

*Conclusion*. Recent research indicates that bulimia occurs at any point along the underweight-overweight continuum. It also suggests that the basic clinical and psychological features of the disorder, some of which are very severe, are similar irrespective of body weight.

*Implications*. These findings have two very significant implications for teachers. First, teachers committed to preventive education concerning bulimia should include material about such topics as the need to diet, negative body image, low self-esteem, and obsession with food. This will help

students overcome their tendency, as products of our culture, to transform three mistaken equations—"bulimia = overeating = obesity = bad"—into the simplistic conclusion that bulimics should just stop eating so much or they will get fat.

Second, the increasingly popular term "normal-weight bulimia" has inadvertently reinforced the myth that bulimia is less serious than anorexia nervosa. It is a sad irony that in our culture the modifier "normal-weight" implies that someone is not really ill. Teachers need to make students aware of a simple truth: bulimia at any body weight is associated with an increased risk of chronic social maladjustment, substance abuse, depression, and suicide.

## Bulimia Is Not an Addiction to Food

*Conclusion*. Bulimics who have never heard of Overeaters Anonymous speak of their disorder as an "addiction" or a "compulsion." Nonetheless, the addiction model of bulimia must be rejected on the grounds that it overlooks the influence of semistarvation and unintentionally contributes to bulimic attitudes and practices.

*Implications*. Many schools across the country use an illness-addiction model to educate their students about alcohol and drug abuse. Teachers should try to keep this perspective separate from discussions of bulimia.

## The Course and Consequences of Bulimia

*Conclusions*. As a rule bulimia grows out of common adolescent concerns and the widespread tendency to use food and/or dieting to control emotional unrest. Bulimia often begins after a period of intense dieting. Unlike restricting anorexics, however, bulimics cannot deny their hunger or their emotional needs, and so they turn to food instead of away from it. But loss of control and/or weight gain

generate anxiety, which in turn motivates dieting, and a cycle is begun. With the introduction of self-induced vomiting and other forms of purging, bulimics often manage to lose weight while continuing to binge. This sense of control turns out to be a vicious illusion, and ultimately the bulimic is bound up in purging to binge and bingeing to purge. Looking good, being in control, and feeling good about oneself become empty phrases as they are superseded by obsession, interpersonal conflict, physical illness, and depression.

*Implications.* This chapter concludes with the same advice given in response to what is known about the course and consequences of anorexia nervosa (see Chapter 2, pp. 37–61). Like anorexia, bulimia has a normal beginning and an abnormal, if not deadly, conclusion. Material about the full-blown disorder is likely to be more interesting to students, but understanding how it originates better serves the purpose of preventive education. Therefore, teachers and their students are encouraged to (1) list and examine various adolescent concerns, (2) discuss the ways in which adolescents cope with their problems, and (3) carefully consider the distinction between short-term and long-term solutions (14). This problem-solving strategy helps remove bulimia and prevention from the realm of clinical psychology and place them in the context of the student's life.

## References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (DSM–III). 3d ed. Washington, D.C.: APA, 1980.
2. Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia.* Baltimore: Johns Hopkins University Press, 1985.
3. Boskind-White, M., and White, W. C., Jr. *Bulimarexia: The Binge/Purge Cycle.* New York: W. W. Norton, 1983.
4. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion.* New York: Doubleday, 1983.

5. Enright, A. B.; Butterfield, P.; and Berkowitz, B. "Self-Help and Support Groups in the Management of Eating Disorders." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 491–512. New York: Guilford Press, 1985.

6. Fairburn, C. G. "Cognitive-Behavioral Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 160–92. New York: Guilford Press, 1985.

7. Gandour, M. J. "Bulimia: Clinical Description, Assessment, Etiology, and Treatment." *International Journal of Eating Disorders* 3 (1984): 3–38.

8. Garner, D. M. "Problems with the Overeaters Anonymous Model in the Treatment of Bulimia." *NAAS Newsletter* 13 (January–March 1986): 1–2. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

9. Garner, D. M.; Garfinkel, P. E.; and O'Shaughnessy, M. "The Validity of the Distinction Between Bulimia With and Without Anorexia Nervosa." *American Journal of Psychiatry* 142 (1985): 581–87.

10. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.

11. Johnson, C., and Berndt, D. J. "Preliminary Investigation of Bulimia and Life Adjustment." *American Journal of Psychiatry* 140 (1983): 774–77.

12. Johnson, C.; Lewis, C.; and Hagman, J. "Bulimia: Review and Synthesis." *Psychiatric Clinics of North America* 7 (1984): 247–73.

13. Johnson, C., and Maddi, K. L. "The Etiology of Bulimia: Bio-Psycho-Social Perspectives." *Annals of Adolescent Psychiatry* 13 (1986): 253–73.

14. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

15. Mitchell, J. E., and Pyle, R. L. "The Bulimic Syndrome in Normal Weight Individuals: A Review." *International Journal of Eating Disorders* 1 (1982): 61–73.

16. Mitchell, J. E., and Pyle, R. L. "Characteristics of Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 29–47. Minneapolis: University of Minnesota Press, 1985.

17. Neuman, P. A., and Halvorson, P. A., *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists.* New York: Van Nostrand Reinhold, 1983.

18. Norman, D. K., and Herzog, D. B. "Persistent Social Maladjustment in Bulimia: A One-Year Follow-Up." *American Journal of Psychiatry* 141 (1984): 444–46.

19. Peele, S. *How Much Is Too Much?* Englewood Cliffs, N.J.: Prentice-Hall, 1981.

20. Pope, H. G., Jr., and Hudson, J. I. *New Hope for Binge Eaters: Advances in the Understanding and Treatment of Bulimia.* New York: Harper and Row, 1984.

21. Pyle, R. L.; Mitchell, J. E.; and Eckert, E. D. "Bulimia: A Report of 34 Cases." *Journal of Clinical Psychiatry* 42 (1981): 60–64.

22. Wooley, S.C., and Wooley, O. W. "Intensive Outpatient and Residential Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 391–430. New York: Guilford Press, 1985.

CHAPTER 5

# Amy's Story: The Personal Side of Bulimia

Parallel to Chapter 3, this chapter presents the edited transcripts of interviews I conducted separately with an 18-year-old Caucasian girl (referred to as "A" for "Amy") and her upper-middle-class parents. Throughout my conversations with these attractive, intelligent, vivacious, and articulate people, I found it hard to believe that their family had been the center of a maelstrom called bulimia.

## The Adolescent

*ML*: How would you describe your eating disorder?

*A*: My experience basically consisted of dieting *really strictly* for a short period of time, and then not being able to put up with the strictness of it, and then going off on a binge that would last for a period of time, and then going back on the diet.

I never really got into purging. I had a few episodes where I forced myself to vomit, but I never used diuretics or anything.

*ML*: What did your "strict" diet consist of?

*A*: I would come up with whole bunches of really stupid things, like all day the only thing I could eat was salad. Usually I would limit myself to 500 calories a day or something like that, 'cause I was impatient, too. I wanted to lose the weight *now*, so I really made it strict on myself.

*ML*: Did that involve skipping meals?

*A*: Yes. The kids at school never knew how I could survive on never eating lunch, 'cause I never did. And I never had problems eating around other people, that was when I was always my strongest. It was when I was by myself—alone—and usually at home, that I had all my problems controlling my food intake. I was never out of control eating with other people.

*ML*: You were eating 500 or so calories a day. How long would that last?

*A*: It *couldn't* last more than three days or so, sometimes even less than that. It worked out to be about a three-day pattern: bingeing for three days and dieting for three days and bingeing for three days. . . .

*ML*: While you were dieting, were you hungry?

*A*: Oh yeah. Except, after a while, I screwed up my appetite so bad that I couldn't tell when I was hungry or when I wasn't. . . . When you binge, you screw up the part of your brain that tells you to stop when you are full, so even to this day I really don't know when I am hungry and when I am not. I just have to go by what's considered normal, instead of what my body says. I think I can reprogram myself again, but I haven't gotten to that point yet.

*ML*: What were the binges like?

*A*: I always could tell when I was going to binge. I had this feeling, like I don't know what, like in the base of my stomach I knew that I was going to binge later that day. I don't know, I felt my control giving way or something.

I would come home from school, throw my books down, and immediately go to the kitchen and just start opening up the pantry, the cupboards, and the refrigerator to find something sweet. I love sugar and that's what I would go for first—anything with sugar that I could consume fast—cookies and candy. If we didn't have anything really sweet, then I might walk to the store and buy a bag of candy bars. I would eat those all the way home. Then I would go to my room; I would hide

this from people because I was really ashamed of it. That's part of the reason why I went out to buy food, too, because I didn't want my family to know, plus I caught a lot of punishment from my mom for eating all the food. So I would go in my room and finish off the candy bars and then maybe go and have dinner with the family and eat a lot—I'd outeat everyone in my family, including my father. I might take a little break from eating after dinner. Then I would go back to the kitchen and eat leftovers. Then, after the family had cleared away and gone off to their separate corners, I would start eating again: leftovers, graham crackers, crackers, cheeses; never vegetables—I could never binge on lettuce. And then I'd go to sleep. I would be full. . . . I would be full even before I finished the bag of candy bars, but that wouldn't stop me.

*ML*: Did you enjoy the taste of the food?

*A*: I ate it too fast, really, to enjoy it, which makes it funny as to why it had to be sugar, 'cause I really didn't care that much about what it tasted like. . . . I didn't enjoy anything about it. It's a scary feeling, because you're eating and you can't stop eating but you want to.

*ML*: So you would eat continuously from the time you came home from school?

*A*: Yeah. I was usually all right at school and before school, but after school was when my control gave way. And my food intake wasn't limited to carbohydrates and sugar. I've eaten stuff like raw bacon and cold leftovers—cold steak, cold mashed potatoes, cold stuffing—just gross stuff; it didn't matter what it tasted like, just as long as I was eating.

*ML*: How old were you when all this began?

*A*: I was about 13; I kind of eased into it, but it started in junior high school.

*ML*: The dieting started? Or the dieting and bingeing together?

*A*: The bingeing started first. I started using food before I started using dieting.

*ML*: Why was that?

*A*: I think it started because I was really unhappy in junior high school. I didn't know very many people. I think in retrospect I was a little bit more mature or something than most other kids, so I couldn't be a kid, I couldn't act like a kid. And when you're in junior high, you know how kids can be really kind of cruel to you, so I got made fun of a lot. I had a really bad self-image as a result, and I couldn't act right, I couldn't be the right way.

*ML*: Were they making fun of your appearance?

*A*: No, they were making fun of my behavior, and that's when I started eating. Then after a while I started blaming their making fun of me on my weight, even though they didn't make fun of my weight.

*ML*: How tall were you and how much did you weigh at that point?

*A*: I was about 5 feet tall, and, when I started, 100 pounds. But then progressively through my seventh grade year I worked my way up to 104 pounds, and then by the end of the eighth grade I was 119 pounds. By the end of my freshman year I was 125, and that was my highest.

*ML*: As you were gaining weight, were you bingeing and dieting, bingeing and dieting?

*A*: The whole time. [Laughs] The dieting didn't seem to work. But I was scared to stop dieting because I was sure that, if I didn't diet I would weigh 800 pounds. I was sure that the dieting was what was keeping me from going clear off the chart with my weight.

*ML*: Did the dieting and the bingeing get worse as time went on?

*A*: Yes, it got lots worse. The quantities of food got more, and the diets got stricter. I got more desperate because my weight went up, and I was feeling worse and worse. People thought I was a happy person, but I wasn't. I was miserable.

*ML*: Did you begin purging at that time or exercising or doing something besides restrictive dieting?

*A*: Yes, inadvertently. I did extra exercises and stuff. I would walk for three hours trying to work off a binge sometimes. Occasionally, I would purge, but I really could count on one hand how many times I did that. Usually I purged after I had been what I thought was very successful on a diet—you know, for a week I had been good—and then I binged. Then I would want to counteract that binge and so I would do something like try to throw up. But I didn't do that very often, because I wasn't good at it and I hated it. . . .

I also took diet pills, the brand name ones you buy at the drugstore. When you diet heavily you're hungry, and I thought this would help me, but it didn't. My mom caught me when she found them. And one of the few times I forcibly vomited I did it with syrup of ipecac, 'cause I couldn't do it with my finger. I got it at the drugstore. The diet pill thing, the bouts of them, didn't last very long. I think I used them two separate periods. I didn't like to use them; they made me shake.

*ML*: A lot of us have idiosyncrasies when it comes to eating and other parts of our lives, but we might not define them as a "disorder." In what ways were your dieting and bingeing more than idiosyncrasies?

*A*: Quantity is probably part of it. Eating past fullness is part of it, I think, since it is appropriate to eat past fullness on Thanksgiving, Christmas, and Easter, but not every day for three days in a row and then three days later. And the secrecy about it; sometimes I would take food from the kitchen into my room, sneak it in when nobody was looking. Oh, and I weighed myself five times a day. When I was dieting I wanted to see how good I was doing, and when I was bingeing I wanted to see how bad I was doing. I was very concerned about my weight. I used to come home crying to my parents that I was too fat.

*ML*: At that time, how tall were you and how much did you weigh?

*A*: I was between 5' and 5'1" and my weight was between 104 pounds and 135 pounds. I always felt too fat; I was never happy with my weight.

*ML*: So you felt fat at 104 pounds and fat*ter* at 135.

*A*: Yeah, but always *over*weight.

*ML*: I'm interested in the discrepancy between what one reads in a table—I'm X inches tall and I have this body frame and so I ought to weigh this many pounds—versus how one *feels*. Did you ever feel that discrepancy—your mother or somebody would say, "You're *not* overweight" or "You're not fat," yet you felt differently?

*A*: Yeah. At one time I thought 5'1" and 95 pounds was *it*. At that time, if anybody told me anything different, inside there was kind of a resistance against it; they were wrong; anything above 95 pounds is too fat for me. It was a physical feeling in my heart; it caused a conflict when somebody else gave me a different number.

*ML*: What would it mean to weigh 95 pounds? Did you consciously associate anything with that lower end?

*A*: I thought boys would love me . . . and I would be a better dancer. . . . And, oh, I used to deny myself going shopping. I wouldn't let myself get clothes because I thought I was too fat. Once I got to that weight, then I could go shopping and I would have lots of pretty clothes. . . . The day you hit 95 pounds everything becomes wonderful.

*ML*: How did you feel about yourself as you were dieting and bingeing?

*A*: I felt miserable about myself. When I was dieting, everything was hunky-dory. When I was in control, I felt good about myself. Then my room was neat, then I could do my homework, then I thought I was prettier; I looked at myself more and liked myself a lot better when I was dieting than when I was bingeing.

When I was bingeing, there was nothing that I could find in the whole world that was good. It affected my ability to function, because when I was bingeing I couldn't do my homework, I couldn't keep my room from being a mess, I didn't care about my appearance, I couldn't be nice to my family. . . . It pretty well put me out of function, except in school, where I could put on an act, but I couldn't hold it at home, too.

*ML*: You began in the seventh grade. How long was it until it became apparent to your family that something was wrong?

*A*: In the summer between my freshman and sophomore years in high school, my mom read an article about bulimia. She said, "Here, look at this, it seems like you have a lot of these problems." I think that was when something started to click. Then in the autumn of my sophomore year I called a psychologist myself, but I didn't know what it was about. I knew that I was unhappy, but I didn't relate it to dieting. I thought my only problem was that I couldn't control my diet—that I couldn't stay on the diet long enough to do any good.

So I got help then, but my parents really didn't realize the seriousness of it, I don't think, until later on. My mom had baked a whole bunch of Christmas cookies early and had frozen them in a big freezer in the basement. I ate most of them still frozen. I think that was when she realized that this was not normal. She was really irritated and angry, but she also realized that there was a problem. But I think a lot of times they just thought I could help it if I wanted to, but that I didn't want to. They thought that, well, you know, "It's easy: if you want to diet, just stop eating, and please stop eating our Christmas cookies." But I think that during my sophomore year they grew to understand that I couldn't control myself. By that time I was crying and difficult.

*ML*: So there was a period of time when *you* were very much aware that things were out of control?

*A*: But I didn't know it was food. I went to a psychologist once in the fall and she recommended me to an eating disorders specialist, so apparently from talking to me she could gather that it was food-related.

*ML*: What happened once it became apparent to your family that something was wrong?

*A*: Well, clear through my junior high years I was impossible to get along with. I felt so bad and I just needed an outlet, and my outlet was food and home and my family. I yelled and screamed, especially at my mom. . . . I'm sure they wanted to send me away at that time because I was just impossible. But they didn't understand, so they couldn't help; they just aggravated it, and I made life real unhappy. I set my parents against one another. . . . that was what was going on, just a lot of hostility.

*ML*: Was it difficult to admit to your folks or to a therapist or to yourself that bingeing and dieting were out of control?

*A*: It was at certain points. When I wanted to get help in the fall of my sophomore year, it would have been easy to admit. But, between that time and the summer when I got help, I worked myself into a state where I didn't want to. I got worse and worse and I didn't want to admit that there was a big problem, but I knew there was something wrong. Sometimes it was very hard to admit to my parents, especially when I was in a binge. When I was in the process of bingeing, I *wanted* to be bingeing—not really—I *needed* to be bingeing. So I didn't want to admit it, because that meant I would probably have to stop.

*ML*: Do you recall what triggered the decision to get help?

*A*: Yeah. I wanted to be able to lose weight, that's why I got help. [Laughs] Little did I know that wasn't what it was all about.

*ML*: How do you feel about the treatment?

*A*: I feel *real* good about it, that it was real

successful. I also feel it's necessary. I know I couldn't have done it by myself; I don't think anybody can.

*ML*: So how are things for you now?

*A*: Better. I still struggle with it, and it still goes up and down. Right now, I haven't had any problem with it. It's less desperate now. Bingeing now is not bingeing; it's overeating. And I don't diet anymore. But I still deal with a "people-don't-like-me-'cause-I-am-fat" frame of mind.

*ML*: How tall are you now and how much do you weigh?

*A*: 5'1" and 115 pounds.

*ML*: Do you "feel" fat?

*A*: Yes, I feel fat. I'm still not happy with my weight. I feel that I could lose weight, that I could maintain a lower weight, and I'm still impatient about it—I want it now!

But I think now my life doesn't depend so much on how I am doing on the diet. My life doesn't have to be *bad* when I am bingeing, and *great* when I am dieting, or great when I'm not bingeing. I can react to my environment instead of having my feelings depend on what I've eaten. I'm a lot less likely to keep my weight from letting me do things; I gave up dancing for a couple of years during the time I was bingeing because I thought I was too fat. Now I am dancing again.

*ML*: Do you still binge occasionally?

*A*: Yes, I do. I haven't really binged to the magnitude that I did several years ago. Now a binge may consist of a couple of candy bars and five graham crackers or something like that.

*ML*: Is the feeling different? Is there still the same need to eat?

*A*: No, the feeling's kind of the same. Right now I work a lot on trying to find out why I just binged. I write down stuff that I'm feeling, or stuff that's happened that could have caused it. But still there's that need that I can't really place.

*ML*: Do you have any advice for middle school or high school students?

*A*: My most important piece of advice would be to get help. I know it's hard a lot of times because parents don't even understand it, and they don't want to say, "My kid's got a problem." But, especially bulimics tend to know that what they're doing is uncool. So I would suggest that, if they can't go to their parents for help, go to *somebody*. Hopefully, the counselors at school or the teachers will be informed enough that they know how to deal with it.

## The Parents

*ML*: When did you first become aware that something was wrong with your daughter?

*Mom*: When she was in junior high school, I first realized that she had a problem with her concept of her weight, with radical changes in her weight, and with her self-image. I wasn't aware how extensive the problem was until the end of her eighth grade year, maybe going on into her ninth grade year.

*ML*: What do you mean by "radical changes in her weight"?

*Mom*: Well, there would be a few months when she would seem to be at a relatively normal weight and she would be pleased with herself. Then she would put on 10, 15, 20 pounds, and she would be displeased with herself, and then you could see that she was making changes in the weight without staying at a simple weight. At first we expected that, because then she was 12 to 13 years old and going through puberty and some changes. So we felt that this was just normal and basically that's how we accepted it. And then we realized that she was not pleased with herself and had a definite problem with her own image of herself.

*Dad*: Like most bulimics, she was not heavily overweight. She was maybe, at the maximum, 5 to 20 pounds overweight, and that would fluctuate radical-

ly. One time during this three-year period she was *under*weight. She managed to overcontrol herself and really got thin. But that did *not* help her psychologically, although her body was very good-looking and thin.

*ML*: She was not pleased with how she looked?

*Mom*: Yes. And she also was not pleased with how her peers rejected her. She felt that, anyway. We're not so certain, and other adults and teachers didn't feel that way, but the important thing is that she felt that way.

*ML*: Did she connect that unpopularity with her weight?

*Mom*: At times she would.

*Dad*: Yes, but I don't think that's what set it off. I believe it was her intellectualism and "adultness" and rapid maturity; these would have set her off anyway—she was never a kid. She always got along better with adults than with children her own age.

*Mom*: She was a perfectionist.

*ML*: When did you begin to see that she was having a problem with eating and weight, rather than "fitting in"?

*Dad*: We never saw that until it was almost too late. There was a huge personality change. She was just not pleased—and that's a mild way of putting it—with anything that happened inside the family. She felt that everything was bad, and violence erupted more times than not; there was a strain on everybody.

*Mom*: Yes. I guess the only thing that kept going through my mind was "We're communicating—it's negative—but at least we're communicating." It was very stressful for both of us. There was erratic behavior, and I wasn't certain just whose fault it was and what the reasons were. We were all making some changes. I was getting going in a job again and gradually spending a little bit more time away from the family, and I thought maybe that was it. I knew her behavior was not normal, yet at the same time I

kept thinking, "Let's give this some time. I mean, she's 12, 13, 14 years old; let's see what happens."

*Dad*: At first it wasn't bad enough for *us* to make a huge commitment. Instead we said, "Everybody in America overeats, just don't overeat as much. It'll be OK. Go dance a little bit more, or run after dinner, and it'll be OK." And that went on for about a year, I imagine, which didn't really help anything.

*Mom*: Actually, our middle daughter was the first one who came to me in tears, very upset, and said her sister "was vomiting last night and I don't believe she's sick." And I said, "I don't believe she is either," and then right away it started to click in my mind that there could be a problem. And shortly after that I read an insert on eating disorders prepared by the local mental health association for our neighborhood paper. Now I had known about the various eating disorders, because I have been involved in health and fitness for a good many years. In fact, I had talked with and knew a lot of adult women with bulimia, but I just didn't equate this with my daughter. When I read a list of the symptoms of bulimia—I thought, "Oh, I think we could have something here." And I gave it to my daughter and asked her what she thought about it. She said, "This sounds just like me."

*Dad*: But you've passed by the years of pain and suffering. It was kind of a normal progression, a teenager wanting to be free, the hostility, and not knowing your place, and all that, which was fairly normal. This passed into *rage*, which is not normal. But it was a slow progression.

*ML*: Is it fair to say that your initial impression that something was wrong was more one of emotional conflict and emotional strife, as opposed to bingeing or food missing from the refrigerator?

*Mom*: Yes, right; that came later.

*Dad*: The psychological aspect—the hostility—came a *lot* before we started noticing *huge* amounts of food missing. We both knew what bulimia was—we called it bingeing—but it's different reading about it and

then having to live with the total person, not the binger, but the manifestations of what that does to a teenager psychologically in a period of time when she is not really that stable anyway.... We just weren't smart enough to catch it....

*ML*: When did you become aware that she was eating huge amounts of food?

*Mom*: We didn't know how much food. When I *really* became aware of it was when I had baked Christmas cookies about two or three months in advance and froze them, and went to get them after Thanksgiving to make up cookie boxes; they were gone....

*Dad*: Ate them frozen, didn't she?

*Mom*: Yeah, and we're talking about *thousands* of cookies that were gone.

*ML*: What were the things that you saw in that insert article that "clicked" with the experiences that you had?

*Mom*: Bingeing, purging, fluctuations in weight, irrational behavior....

*Dad*: We're not a very violent family, and I'll go out of my way to avoid an argument. But, especially my wife and daughter would get in violent confrontations over something stupid, just so small—whether you should wear a black belt with a black suit or a white belt with a black suit. Most of the time, I don't know why, I took our daughter's side at first. But even when I tried to be compassionate with her during the bad times, it didn't work. Any amount of consolation I gave, and guidance, all the expertise I had, I mean it was just worthless.

*Mom*: And then things started happening, and I started really worrying, and then my daughter all of a sudden said, "I don't want any help." That was when I said, "Well, OK, so much for your privacy—I'm concerned." I mean if it were drugs or anything else, it would be the same thing. And I did find syrup of ipecac one time and that was when I said, "OK, this is it." And I went to my daughter and she agreed.

*Dad*: But we started out slow. First we started not buying the sweet foods or overstocking them. Then we [laughs] chained the freezer.

*Mom*: Yes, we did—we chained the freezer.

*Dad*: But it didn't work, nothing worked. Eventually the bulimic totally loses control. A little thing sets them off at school—a friend doesn't say hello to them or a friend's upset—anything will set them off, and they will eat anything. They are totally out of control—violent behavior—irrational thoughts. . . . Finally, it got so bad, and the family had suffered enough—everybody was yelling at everybody, other people who didn't have problems now were having problems—then we put down our foot and said, "We've got to do something. What's it going to be?"

*ML*: She described her eating disorder as periods of bingeing interspersed with periods of very restrictive dieting. She said it almost became a pattern of three days on the diet and three days off.

*Mom*: But she didn't see that pattern, although it's something I began seeing. I could almost tell when my daughter was going to go through a bad time. Her whole attitude about everything—her appearance, how she responded to me, even how her room looked, just the general organization of her life—would just simply fall apart. Within days it would be, "I'm out of control."

*ML*: Most articles on eating disorders describe bingeing as something that takes place in secret. Are you saying that after a while your daughter's binge-eating was out in the open?

*Dad*: In fact, we saw her eat very seldom.

*Mom*: She did not want to eat at the dinner table. She did not want to participate in any type of family function, especially when it involved food. Once we all went out for a celebration, and she sat in the back seat and cried the whole time because she was on a diet and didn't want to go.

*Dad*: Dinner table was the worst place you could imagine. We still don't eat dinner together. So most

of the family eating migrated into different areas. They ate at baby-sitters' houses or they ate before they came home or they fixed their own, and so we never saw her sit down and eat a whole ham or something. We just noticed that the refrigerator and freezer were empty, sometimes the day after we went to the store.

*ML*: Do you recall how or when you made the decision that enough was enough?

*Mom*: I think it was the syrup of ipecac or shortly thereafter.

*Dad*: We also discovered diet pills around at about the same time. We were really upset then.

*Mom*: We were frightened.

*Dad*: We knew it was something we could not control. So you immediately say to yourself, "Well, you're a rotten parent, you can't handle it, your kid's in trouble, and you probably started it." So now we've got to figure out how to solve this problem and we don't have any idea what to do.

*Mom*: You know, something that affected me—I was sitting in my office, and a woman came to me for a health and fitness evaluation. In the interview she tearfully told me about her problem with bulimia, and as I listened to her I almost . . . I cried all the way home because I thought, "Here I am very compassionate with this woman, and here is my daughter with the exact same symptoms, who must be going through this same turmoil, and I'm telling her, 'Eat 1,000 calories a day,' and working through her diet with her and her exercise program and that's not what she needed."

And then one of the couples she was baby-sitting for—he is a physician—mentioned that there were huge amounts of food gone. By that time we were aware of it—we had already made arrangements for her to see a counselor, but I thought, "Oh, that just isn't like my daughter at all. This child is out of control. If she is doing it at someone else's home, then she really has a problem."

*ML*: Your daughter dates her eating disorder as

beginning around age 13, the beginning of middle school. How long was it between then and the family's decision to get some help?

*Mom*: I believe that would be two years. I would say she was 15 years old.

*ML*: And you describe those years, to put it mildly, as turbulent?

*Dad*: Oh yeah! *I* went to seek professional help.

*Mom*: We both did individually.

*Dad*: You really get to a point where you are against everybody; everybody is against everybody, and no one is pulling in the same direction. It wasn't until we went to the right person—an expert on eating disorders—for professional psychological help that anything changed. And then the change was remarkable, almost overnight, almost from the first appointment. For my money, counseling was an overnight success—a huge psychological change.

*Mom*: The first time she saw a psychologist she came home and she just sat down at the kitchen table and sighed and said, "Guess what's the first thing I am going to do?" I said, "What?" and she said, "Not diet."

*Dad*: The thing you noticed, though, was that her mind was better organized. And then at the same time her social behavior vastly improved. She entered a church youth group and just took the ball and ran with it. She just loved everything about it. And these two things went right hand in hand, the church group and the counseling.

*Mom*: She began to dance again, she was able to go to a dance class again. Before, she loved to dance, but she couldn't look at herself in the mirror.

*Dad*: She'd say, "I look bad, I'm fat"—things like that.

*ML*: Did the eating disorders specialist meet with you folks and talk about what the treatment entailed or what was going to happen?

*Mom*: Over the phone she did say, "I do believe your

daughter has a problem and I do believe she needs therapy." Then we both said, "Whatever we can do—if you need to speak with us or what have you." At this particular time my daughter and I were having a miserable relationship, and so I felt that therapy needed to be something just between our daughter and the psychologist. Our daughter needed to have someone she could go to and not be afraid to discuss anything she wanted to discuss. We told her, "Hey, anything you feel you need to talk to the doctor about, that is fine with us. Don't worry about it."

*Dad*: We tried to be concerned, but aloof. She'd come back from a session and we'd say, "Did it go OK today?"—something open-minded she could say yes or no to, or talk about it if she wanted.

*Mom*: She didn't talk about it for a while. Then she started talking about the sessions, actually educating us, which was really good. There came a period where she would say, "You realize . . ." and then tell us every mistake we made. At first it bothered me a little bit and I was defensive—anybody would be—but, as I thought about it, I came to grips with accepting the fact that I made mistakes, too. But then we worked through that, too, I think, as we were able to talk about a lot of the problems that she felt perhaps we were guilty of. And I think she has accepted the fact, not completely yet, that some parents are not perfect.

The whole family was simply more compassionate with our daughter. I think we finally realized that this was something she couldn't control, but it took me a long time to get to that point. Prior to that time I thought she was eating all my Christmas cookies just for spite. Eventually, I would say, "I have a right to be angry, and I'm angry, but I understand you're out of control."

*ML*: What advice do you have for parents or adults in general?

*Mom*: We've been through it, so I understand how they are feeling—most parents are thinking, "I don't

know about therapy, isn't there something we can do?" And most always I say, "Well, there isn't. I think you've got to go straight for therapy; I don't think there's any other way." And I tell them it often doesn't get better. From my professional experience, I know women who started the bingeing and purging at 13 and now they're 40 or 45 years old and still doing it. Maybe it's with laxatives or other things, but they've still got the problem. They're still very unhappy with themselves.

I refer people to [an eating disorders association] at least to talk, and because there are lots of group programs there as well. And often the [association] will refer them to local psychologists. Sometimes people say they don't think they can afford a psychologist and I say, "Yes, you can, there is always a way."

*ML*: (to Mom) Do you think your occupation in the health and fitness field had any effect on your daughter's concern with her weight and her appearance?

*Mom*: It could very well have. I'm not sure one way or the other. I've never been a thin person. She could see that I certainly don't have a perfect body, but I am still involved in health and fitness. I've never been a radical about it; I am very conservative about exercise and I've never been a person for rigid diets, because I think diets make people crazy. That's why I've always felt that exercise and learning how to use food are nice. But again just by the mere fact that there has always been information around the house and the discussion of it could very well have. . . .

*Dad*: I don't think it set it off, but I think it aggravated the situation once it progressed into an advanced stage.

*Mom*: Our daughter was always a perfectionist and she always liked food. When she was just a little girl, she was a wonderful eater. But she had allergies, and she was so thin and so little, we never said anything about it. When she started eating a lot in junior high,

we were actually pleased: "Thank heavens our daughter has a good appetite."

Then when her problems first began I was very clinical with my daughter. She'd be concerned about her weight and she would come to me from time to time and I'd say, "Well, you eat this amount of calories and you need to exercise this amount." I was not seeing the rest of it. . . . We just tried to do it ourselves.

*Dad*: That was what we did. My wife is into dieting and exercising, and I jog, so we hit her with "You're not running enough" and so forth, and it was absolutely the wrong thing. I don't blame myself 'cause if it happened to another daughter I'd probably do the same dumb things all over again. . . . Our daughter had the talent to dance, a tremendous IQ, and talent in presentation, speaking, and music, but none of it was worth anything to her, because of this block, this bulimic block.

It seemed to be a "wanting" psychological problem. She needed compassion, togetherness, and a sense of worth; she really didn't need diets and a thousand calories per day or running. . . .

CHAPTER 6

# The Extent of Eating Disorders in High School Students

In 1983 Drs. Harrison Pope and James Hudson of the Harvard Medical School invited 450 women attending "a prestigious rural college for women" to complete a questionnaire concerning anorexia nervosa and bulimia (22, 24). The questions used to diagnose these disorders were direct transcriptions of the criteria contained in the *Diagnostic and Statistical Manual (DSM-III)* of the American Psychiatric Association (1; see Table 6–1). The results are startling. Of the 287 (64 percent) who responded, 6 (2 percent) reported a history of anorexia nervosa, 6 (2 percent) reported a history of anorexia nervosa and bulimia, and 36 (12.5 percent) reported a history of bulimia. Even if we make the tenuous assumption that all nonrespondents were never anorexic or bulimic, 10 to 11 percent of the women at this college had a history of eating disorders.

Although surveys of women at other colleges, including coeducational state universities, suggest this figure is accurate, Pope and Hudson were skeptical of such a high lifetime prevalence. So they asked 304 female shoppers at a Boston mall to fill out the same anonymous questionnaire in exchange for a dollar (22, 23). Only four declined to participate. The distribution of ages for the remaining 300 paralleled that for the 13 to 64 range in the United States. The results were depressingly similar to those of their first study. Nearly 5 percent were currently bulimic and another 5 percent had been

bulimic at some time. But the most disconcerting finding was that 9 (11.4 percent) of the 79 shoppers ages 13 to 20 were currently bulimic and another 5 (6.3 percent) had been bulimic at some point in their lives. In other words, the lifetime prevalence of bulimia for the women 21 and over was 7.8 percent, whereas that for the 20-and-under group was nearly 18 percent.

## Epidemiology

Is the prevalence of eating disorders increasing? Is there an "epidemic" of eating disorders on high school and college campuses? Do males ever develop anorexia nervosa or bulimia?

Epidemiology is the branch of medicine and health science that attempts to answer these and related questions (24, 26, 29). Specifically, epidemiologists interested in eating disorders investigate the following:

*POINT PREVALENCE*: Within a given population (such as high school or college students), this is the percentage of people who *currently* have an eating disorder.

*LIFETIME PREVALENCE*: Within a given population, this is the number or percentage of people who have had an eating disorder *at any time*.

*INCIDENCE*: This is the number of *new cases* that can be expected to arise over a certain period of time, for example, six months or a year. Comparisons of the incidence for each of several consecutive years permit conclusions about whether eating disorders are increasing or decreasing.

*ENVIRONMENTAL VARIABLES*: These are sociocultural factors, for example, socioeconomic status, that might increase or worsen the risk of eating disorders when they occur.

*PERSONAL VARIABLES*: These are characteristics of the person, such as gender, that might

contribute to the development or maintenance of eating disorders.

Reading (and writing) about epidemiology, with its emphasis on sampling, diagnostic methodology, and statistics, can be tedious and exasperating. Differences in type of school, ages of students, sampling methods, percentage of respondents, type of prevalence examined, and the definition of bulimia and anorexia nervosa make it difficult to compare studies and to offer general conclusions. In addition, there are few studies of high school students; therefore teachers will naturally find themselves wondering about the extent to which the students who have been surveyed are similar to those they teach. Nonetheless, epidemiological investigations are crucial for an understanding of both the need to prevent eating disorders and the contributing factors on which prevention must focus.

## Anorexia Nervosa

### Prevalence

At this time we simply do not know the exact point or lifetime prevalence of anorexia nervosa. We do know, however, that anorexia nervosa is not rare, as was once thought (21, 27).

The best available data on the point prevalence of anorexia nervosa in high school students was obtained from surveys of British and Scandinavian high school students conducted during the late 1960s and early to mid-1970s (10). The participants in these investigations were middle- to upper-class girls. Together, these studies suggest that the risk of anorexia nervosa is 1 in 175 for high school girls in general and 1 in 100 for those girls attending private school. One of the Scandinavian studies also found that nearly 1 in 10 of the high school girls could be considered to have at least a mild form of anorexia nervosa (10).

The two current studies of lifetime prevalence in high school girls are consistent with an estimated point prevalence of 0.5 to 1.0 percent. In the shopping mall study 2 (2.5 percent) of the 70 girls ages 13 to 20 had a history of anorexia nervosa (23). Around the same time, Pope and Hudson also administered their eating disorders questionnaire to 186 girls and 124 boys attending "a suburban, coeducational school, covering grades 9 through 12, with approximately equal numbers of boarding and day students" (24, p. 47). Of the 155 (83 percent) girls who responded, 6 (3.8 percent, or 3.2 percent of the total sample) reported a history of anorexia nervosa. Of the 107 boys (86 percent) who responded, none reported anorexia nervosa.

## Incidence

Many experts believe that the incidence of anorexia nervosa in middle school and high school girls is increasing (10). Before 1950, there were fewer than 500 cases of anorexia nervosa described in the psychiatric literature; as of 1980 there were nearly 5,000 (27). It is not known for certain, however, whether anorexia nervosa has indeed become more common or whether increased public and professional awareness has resulted in a change in diagnostic criteria and an increase in the number of cases detected, referred, treated, and cataloged.

It is likely that both possibilities represent the true state of affairs to some extent (27). In one New York county the number of new cases cataloged during 1970 to 1976 was double that in 1960 to 1969, with the sharpest increase for females ages 15 to 24 (Jones and others, in Eckert [10]). A review of several classic investigations suggests that the incidence during the 1960s and 1970s was between .35 and 1.5 new cases of anorexia nervosa per year per 100,000 people (10). This is a conservative estimate because a significant number of cases do not come to the attention of psychiatrists (27).

Assuming that the current population of the United States is roughly 225 million, all this means that there are probably between 750 and 3,200 new cases of anorexia nervosa per year in the United States, with an excellent chance that the actual number is at least 10,000! Readers who find themselves wondering about the figures from the late 1970s and early 1980s have verified the pressing need for more current research.

## Prevalence and Incidence: Some Tentative Conclusions

Piecing together the current research, and overlooking the large number of missing pieces, we can arrive at three tentative conclusions about the prevalence and incidence of anorexia nervosa:

1. It is likely that between 1 and 6 of every 200 girls will develop anorexia nervosa between the ages of 12 and 20.
2. That rate appears to be greater than the comparable prevalence reported in the 1960s and 1970s. This suggests, but does not prove, that the incidence of anorexia nervosa in high school students is increasing.
3. As discussed in a later section, the higher the socioeconomic status, the greater the risk.

## Sex Distribution

Based on surveys of patients at psychiatric hospitals and eating disorders clinics, it is estimated that 90 to 96 percent of anorexia nervosa cases are female (2, 10). The only research bearing on this issue is the series of studies conducted by Pope and Hudson (22, 23, 24). In four studies involving 720 females (71 percent) out of a possible 1,020 high-school and college-age respondents, these investigators identified 21 with a history of anorexia

nervosa—2.9 percent of the respondents or, most conservatively, 2 percent of the total pool. In contrast, no cases of anorexia nervosa were reported by the 154 males (69 percent of the total invited to participate) who were included in two of the studies.

This zero prevalence for males does not and indeed cannot contradict clinical observations. Until studies of high school, college, and community males are done, the actual proportion of females to males will remain unknown (10). Clinical studies do suggest, however, that the manifestations of anorexia nervosa in males and females are very similar (2, 10).

## Age of Onset

Anorexia nervosa may develop before 12 or after 50, but in general it begins between 12 and 20 (4, 10, 12). Two independent studies of large groups of anorexics found the peak age of onset to be either 14.5 or 18 (4; Halmi and others in Eckert [10]). This is very significant because these ages coincide with the beginning and ending of high school. It is important to keep in mind, however, that 10 to 30 percent of all cases develop after ages 20 to 25 (4, 10, 12).

## Socioeconomic Status and Other Demographic Variables

The research on point prevalence conducted in the late 1960s and early 1970s suggested an association between anorexia nervosa and privileged status. Thus, during the 1970s, a number of expert clinicians carefully examined the distribution of their patients across the social classes. They found that 50 to 70 percent of their female anorexic patients were from upper-middle-class and upper-class families (12).

The strong association between anorexia nervosa and the upper classes has been

confirmed in a recent study by Dr. Finn Askevold of the National Hospital in Oslo, Norway (3). He evaluated the distribution of anorexia nervorsa and several psychosomatic disorders (such as migraine headache) across the high, middle, and low social classes. All the psychosomatic disorders were evenly dispersed, but anorexia nervosa was found much more often in the upper than in the lower class. Fifty percent of the 112 anorexics in the sample were from the highest class, as compared with only 15 percent of a sample of age-matched women. The very small amount of evidence available concerning social class and male anorexics is contradictory and in need of replication (see Andersen [2] versus Garfinkel and Garner [12]).

It is very important for education staff to realize that anorexia nervosa is not exclusively an upper-class or even middle-class phenomenon (3). Garfinkel and Garner have observed that since 1976 the percentage of their anorexic patients from the upper classes has fallen from 71 to 52 (12). Although other epidemiologists have not reported an increased number of anorexics from the working class, it is Garfinkel and Garner's expert impression that anorexia nervosa is becoming more prevalent among the lower social classes, Black people, and older women (12, 13).

The findings concerning religious background are so variable that only two conclusions are possible: (1) no religious group is immune to anorexia nervosa in its children, and (2) more sophisticated research is necessary before it can be said with any certainty that religious affiliation is a significant risk factor (12).

## Bulimia

There have been five recent epidemiological studies of bulimia in high school students. In general this research examines the point prevalence and correlates of bulimia (that is, the bulimic syndrome) as defined by the *DSM-III* criteria (see Table

6–1). Some of the studies also examine the percentage of students who engage in binge-eating, self-induced vomiting, 24-hour fasting, and other individual aspects of bulimia.

## Prevalence in High School

### *Two Typical Studies*

In 1983 Craig Johnson and colleagues at the Northwestern University Institute of Psychiatry surveyed 1,268 high school girls between the ages of 13 and 19—nearly 98 percent of the girls attending a large Illinois high school with a diverse student body (15). Students were considered bulimic if they binge-ate once a week or more and if they responded yes to each of four basic questions derived from *DSM-III*—for example, "Do you get uncontrollable urges to eat and eat until you feel physically ill?" (p. 17) and "Do you feel miserable and annoyed with yourself after an eating binge?" (p. 18).

Johnson and his associates found a point prevalence of 4.9 percent. In other words, at the time of the survey 62 girls in this large high school were binge-eating in an uncontrollable and miserable fashion at least once a week. When the stringent criterion of *weekly* bingeing was dropped, this figure rose to 105 students (8.3 percent). Of those who were binge-eating on a weekly or greater basis, 11 (1 percent of the total sample) could be considered to have a very serious eating disorder because they also reported at least weekly self-induced vomiting or laxative use.

In 1984 Janis Crowther and her colleagues at Kent State University collected questionnaires from 363 Ohio high school girls who had received parental permission to participate (9). This sample was drawn from four diverse high schools and represented 80 percent of the 48 percent whose parents returned the consent form. Twenty-eight girls (7.7 percent) met the *DSM-III* criteria for bulimia. In addition, the researchers identified a

## Table 6–1. Diagnostic Criteria for Eating Disorders According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, 3d ed. of the American Psychiatric Association*

### ANOREXIA NERVOSA

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.
B. Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.
C. Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make 25%.
D. Refusal to maintain body weight over a minimal normal weight for age and height.
E. No known physical illness that would account for the weight loss.

### BULIMIA

A. Recurrent episodes of binge-eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).
B. At least three of the following:
   (1) consumption of a high-caloric, easily ingested food during a binge.
   (2) inconspicuous eating during a binge.
   (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting.
   (4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics.
   (5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.
C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
D. Depressed mood and self-deprecating thoughts following eating binges.
E. The bulimic episodes are not due to anorexia nervosa or any known physical disorder.[a]

[a]Few experts accept this criterion because it arbitrarily excludes the significant number of anorexics who binge-eat, purge, and otherwise meet the criteria for bulimia (see Chapter 2).

---

*Copyright © 1980 by the American Psychiatric Association, Washington, D.C. Reprinted with permission.

group of 16 students (4.4 percent) who were concerned and depressed about frequent and uncontrollable binge-eating, but who did not meet the formal criteria for bulimia. Thus, if Crowther had used Johnson's less restrictive criteria for bulimia, the comparable point prevalence would be 44 of 363, or 12 percent.

When the criteria for bulimia were tightened to include a weekly or greater frequency of bingeing, 19 girls (5.2 percent) could be considered bulimic. If only the cases involving at least weekly bingeing *and* weekly vomiting or laxative use are considered, then 2.8 percent of the total Ohio sample could be said to have a very serious bulimic disorder.

### *Comparison Across Studies*

The Illinois and Ohio studies make it clear that problematic binge-eating and the syndrome of bulimia are considerably more prevalent than anorexia nervosa. This impression is confirmed by Table 6–2, which shows the prevalence of bulimia reported in the Illinois and Ohio studies, plus three other recent studies: Massachusetts (24), Louisiana (7), and Arizona (17). For comparison purposes Table 6–2 also presents prevalence data from 98 percent of a recent freshman class at the University of North Dakota (25).

### *Conclusions*

Despite potentially significant differences in methodology and return rates, the studies summarized in Table 6–2 are remarkably consistent in suggesting that—

1. At any given time 6 to 10 percent of all high school girls are bulimic according to the *DSM-III* criteria. This is a smaller percentage than the figure of 8 to 19 percent reported for college women in the early 1980s (20), but it is very similar to the point prevalences found in more recent studies (18; Ollendick and Hart, cited in Stark [28]; 25).

Table 6-2. Point Prevalence (in Percent) of Bulimia in Five Samples of High School Girls and One College Sample

| | High School | | | | | College |
|---|---|---|---|---|---|---|
| Variable | Illinois (1984) | Ohio (1985) | Mass. (1984) | Louisiana (1984) | Arizona (1984) | N. Dakota (1983) |
| Meets less rigid criteria for bulimia | 8.3 | 7.7 | 6.5 (0)[a] | NCS[b] | NCS | 7.8 (1.4) |
| Bulimia with weekly bingeing | 4.9 | 5.2 | NCS | NCS | NCS | 4.5 (0.4) |
| Bulimia with at least weekly bingeing and purging | 1.0 | 2.8 | NCS | 1.0 | 2.0 (1.0) | 1.0 (0.3) |

*Notes:*
1. Numbers in parentheses refer to the prevalence for males.
2. The categories are not exclusive, i.e., the first subsumes the next two and the second subsumes the third.

[a] The statistic for the Massachusetts study is a lifetime prevalence.
[b] NCS = No comparable statistic.

2. Five percent of high school girls have a serious bulimic disorder characterized by weekly involuntary eating binges and considerable misery.
3. One to two percent of all high school girls have a very serious bulimic disorder involving *at the very least* weekly binge-eating and weekly self-induced vomiting. This estimate of the rate of severe bulimia is very close to the figure of 1.0 percent for freshman women at the University of North Dakota. It also duplicates the figure of 1 to 2 percent that emerged from the Boston mall survey (23) and from a survey of 369 young women who were attending a family planning clinic in Britain (11).
4. The risk of bulimia is significantly less for males than for females, but males are not immune to even severe forms of this eating disorder.

## Incidence

As is the case for anorexia nervosa, many experts and educators believe that the incidence of bulimia is increasing. This contention is supported by the Boston shopping mall study in which the lifetime prevalence of bulimia for the 13 to 20 age group was more than twice the lifetime prevalence for participants 21 and over (23; see pp. 124–25 of this book). As acknowledged by Pope and Hudson, however, "no firm conclusion is possible" (23, p. 293) because theirs is the only recent study that directly addresses the issue and there are no comparable studies from 10 years ago.

## Prevalence of "Bulimic" Symptoms in High School

Table 6–3 presents the percentage of female high school students in the Ohio, Illinois, and Arizona samples who report engaging in the individual binge-eating and weight control practices that collectively comprise the disorder of bulimia.

### *Binge-eating*

Substantial variability in sampling techniques and questionnaire construction make it difficult to compile tables like this and to compare their data with surveys of older students and community members. For example, no two studies define a "binge" in exactly the same manner. Nonetheless, a conservative reading of Table 6–3 indicates that 1 in 5 high school girls binge-eats on a regular basis, while 1 in 6 does so weekly. A comparison with the results from other recent surveys yields the tentative but unsettling suggestion that the percentage of American high school girls who binge-eat at least weekly is significantly greater than the rates of 2 to 10 percent reported for American college women (18, 19) and a large community sample in Britain (11).

Table 6–3. Prevalence of Binge-Eating and Evacuative Practices in Female High School Students

| Bulimic Practice | Percentage of Students Reporting This Practice | | |
|---|---|---|---|
| | Ohio (n=363) | Illinois (n=1268) | Arizona (n=1082) |
| Meet *DSM-III* criteria for bulimia | 8 | 8 | 2–3 |
| Binge eating at least monthly[a] | 17 | 48 | 25–31[c] (17–25) |
| Binge eating at least weekly | 11 | 21 | 10–16 (10–11) |
| Self-induced vomiting at least monthly[b] | 5 | 10 | 3–4 |
| Self-induced vomiting at least weekly | 2 | 4 | 1–2 |
| Laxative use at least monthly | 5 | 6 | 2–3 |
| Laxative use at least weekly | <1 | 3 | 1 |
| Fasting at least monthly | 36 | NCS[d] | 13–14 |
| Fasting at least weekly | 11 | NCS | 7 |
| Diet pill use at least monthly | NCS | 12 | NCS |
| Diet pill use at least weekly | NCS | 6 | NCS |

*Note*: With the exception of the Illinois study, the data reported do not permit a separation of bulimic vs. nonbulimic students.

[a]Each report of a monthly prevalence includes the figure for weekly prevalence.
[b]In the Louisiana study (Carter and Duncan [7]), 9% of the 421 girls indicated they "currently" induced vomiting for reasons of weight control.
[c]Figures for the Arizona study are based on the prevalence of answers to the items "Eat so much that your stomach hurts" and "Feel completely out of control when it comes to food." Numbers in parentheses are the rates for males.
[d]NCS = No comparable statistic.

### *Purging*

The rate of frequent self-induced vomiting (2 to 4 percent) and laxative use (4 to 6 percent) in high school girls parallels the prevalence of bulimia in that population. In the few surveys of college students that permit a direct comparison, less than 1.5 percent reported purging on a weekly or greater basis (14, 19, 25). This raises the disturbing possibility that the number of younger students resorting to frequent purging is increasing.

### *Fasting and Diet Pills*

The percentage of high school girls who regularly fast and/or use diet pills is at least double the prevalence of bulimia in that population. The rate of frequent fasting is very similar to that reported in the study of North Dakota freshmen (25). But, in yet another disturbing comparison, the percentage of Illinois high school girls who reported using diet pills *weekly* (6 percent) in 1983 is equivalent to the figure for Cornell college students (6.5 percent) who admitted having used them at all before 1981 (14).

## Sex Distribution

As is the case for anorexia nervosa, high school girls and college women are significantly more likely than their male counterparts to develop bulimia (20, 22). Based on college populations and heterogeneous groups of patients, it is likely that female bulimics outnumber males at least 9 to 1 (20).

### *Bulimia in Males*

There is too little research with male participants to make any firm conclusions about bulimia and bulimic practices in males. Pope and his associates reported no cases of bulimia in 107 boys

attending a Massachusetts high school (24). Based on the survey of Arizona high school students (17) and two surveys of college males (14, 25), however, it appears that 1 to 6 percent of young men may be bulimic according to the less restrictive criteria of *DSM-III*. This figure seems plausible in light of the observation that 27 percent of the freshman men at the University of North Dakota admitted having attempted to control their weight "by self-induced vomiting, laxative use, diuretics, enemas, or fasting" (25, p. 79). In general, the risk of severe bulimia (frequent bingeing and purging) seems to be less for males than females (14, 19).

It is important for education staff to realize that the risk of bulimia may be significantly greater for those high school boys who participate in activities that tend to overvalue low body weight, such as wrestling, gymnastics, dance, and distance running. In this context bulimic practices may develop as "creative" reactions to deprivation or may be communicated directly by coaches or other athletes as legitimate means of "making weight" (13, 21).

## Age of Onset

Most bulimic disorders develop between the ages of 15 and 20, with the modal age being around 16 to 18 (16, 20, 21). It should be noted that this is a statement of statistical probability; ten (16 percent) of the 62 bulimic high school girls in the Illinois study were 13 to 14 years old (15). Similarly, for the bulimic girls in the Ohio study the mean ages of onset for binge-eating and purging were 14.2 and 14.8 years, respectively (9). Thus, although bulimia tends to be a disorder of later adolescence, eighth and ninth graders are vulnerable. In fact, the study described next suggests that up to 30 percent of all bulimics develop the disorder before age 14 or after age 23 (16).

## Socioeconomic Status/Demographics

In the early 1980s Craig Johnson and colleagues received a set of surveys concerning bulimia from 361 women who had initially written to the Anorexia Nervosa Project at Michael Reese Hospital in Chicago for information about this eating disorder (16). "The typical bulimic who participated in this survey was a white, single, college-educated female in her early 20s who comes from an upper- or middle-class family of more than one child" (p. 162).

This description is nearly identical to the image of the "typical bulimic" or "bulimarexic" as popularized (perhaps inadvertently) by Marlene Boskind-White and William White (5). The bulimics these psychologists worked with at Cornell University tended to be "white middle-class adolescents and women in their twenties with a strong orientation toward academic achievement and a traditional lifestyle" (p. 33). According to Boskind-White and White (5), these women are paradoxes to themselves and to their therapists. In general they are intelligent, attractive, capable, and perfectionist—on the outside a perfect package of modern American womanhood. On the inside, however, they feel worthless, lonely, empty, out of control, and "fat."

The studies by Johnson and Boskind-White suggest that those at greatest risk for developing bulimia are those most likely to develop anorexia nervosa—privileged young white women. However, medical writer Janice Cauwels (8) rightly cautions us that the now stereotypical portrait of the bulimic as a highly polished girl with an empty core is probably the result of a sampling bias or media bent on exploiting the association between bulimia and well-known "golden girls" like Olympic gymnast Cathy Rigby. Cauwels contends that bulimics are a much more heterogeneous group than anorexics. This argument is supported by the finding that bulimic high school students from Illinois and Ohio do not differ significantly from their nonbulimic peers with regard to race, parents' marital status, parental education, and family socioeconomic status (9, 15).

# Conclusions and Implications

## The Prevalence of Eating Disorders

*Conclusions.* People often speak of eating disorders as an "epidemic" on today's middle school, high school, and college campuses. This is probably too strong a label for the prevalence of either anorexia nervosa or bulimia. Yet the data reviewed in this chapter leave no doubt that eating disorders are distressingly prevalent. At any specific time 1 in every 100 to 150 high school girls is anorexic and 5 to 10 percent are bulimic. Given that another 1 to 3 percent would have borderline eating disorders, this means that in a class of 200 high school girls, 15 to 25 will currently have an eating disorder.

These statistics are appalling, but the problem is more extensive than that implied by data on point prevalence. Research on the lifetime prevalence of bulimia suggests that, if present trends continue, by age 18 approximately 10 percent of high school girls will be or will have been bulimic; by age 20 that figure will have risen to 10 to 17 percent; and by age 23 or so nearly 19 percent or 1 in 5 will meet or will have met the *DSM-III* criteria for bulimia (23, 24). It is also likely that by age 20 at least 2 percent of the women who have attended high school will be or will have been anorexic.

*Implications.* Eating disorders are a fact of life on middle school and high school campuses. On the basis of prevalence alone they deserve the serious attention of teachers, counselors, nurses, administrators, parents, and other students.

## The Incidence of Eating Disorders

*Conclusions.* Many experts and many teachers believe that the rate of eating disorders is increasing. The available research data are sparse,

but in general they reinforce this belief. Moreover, there is some indication that today's high school students are more likely than their predecessors to binge-eat frequently and to use evacuative methods (such as self-induced vomiting or laxatives), 24-hour fasting, and diet pills in order to control their weight.

*Implications*. On the one hand, teachers should be leery of the phrase "epidemic" in regard to eating disorders. On the other hand, it is clear that something significant is happening with respect to the importance of food and weight management for middle school and high school students (see Chapter 7). A discussion of binge-eating and/or the increased use of dangerous weight control techniques might be an excellent starting point for examination of our culture's paradoxical obsession with food and thinness.

## Sex Distribution

*Conclusions*. Girls are at least nine times more likely than boys to develop an eating disorder. This does not mean, however, that boys and young men are invulnerable to anorexia nervosa and bulimia. The current data indicate that 1 to 2 percent of all boys will develop bulimia during their high school years.

*Implications*. Teachers should address their lessons and other remarks about eating disorders to both girls and boys; it is a major error to convey directly or indirectly that eating disorders are a "woman's problem." Moreover, although it is a very sensitive subject for adolescents and adults alike, a discussion of anorexia nervosa and bulimia must at some point come around to the reasons why the vast majority of sufferers are female (see Chapter 7). Teachers should take extra care in preparing themselves for this inevitability. It is imperative that this volatile subject be handled in a manner that addresses and acknowledges sex differences without obscuring the cultural, familial, and biological factors

that place both boys and girls at risk for an eating disorder.

## Age of Onset

*Conclusions.* The age of onset for anorexia nervosa and bulimia is highly variable, but in general the period of highest risk is ages 14 to 20. Anorexia nervosa seems to have two peak ages of onset—14 and 18, while the average age at which bulimia begins is 16 to 18.

*Implications.* These figures reaffirm one of the reasons for writing this book, namely that secondary school teachers and other staff are encountering students at a time when they are very vulnerable to the development of eating disorders. It is an article of faith that teachers and staff can reverse or significantly reduce this vulnerability through their educational and advising efforts (see Chapter 10). In this respect, the transition from middle school to high school and the departure from high school deserve special attention as times of high risk.

The great variability in age of onset is as important as the averages and modal ages. A significant number of cases begin around ages 12 or 13, indicating clearly that middle school students are an appropriate target for preventive education about eating disorders, including programs designed to deemphasize appearances and emphasize self-esteem and positive coping skills. Conversely, the fact that as many as one in five cases of anorexia nervosa and bulimia begin after age 25 serves as an important reminder to teachers that their colleagues, both female and male, are not immune to the development of eating disorders.

## Demographic Characteristics

*Conclusions.* There is a fair amount of evidence to substantiate the stereotypical conception that the anorexic and the bulimic are usually young

white girls from well-to-do or upwardly mobile families. Unfortunately, the most recent data and clinical impressions indicate that these disorders are becoming more egalitarian, perhaps as the cultural obsession with slenderness spreads from the upper to the lower socioeconomic classes (12).

*Implications*. Both the stereotype and the contradictory evidence are very significant for teachers. With respect to the heterogeneity of people with eating disorders, teachers would do well to heed Janice Cauwels's (8) statement that "bulimics are women [girls] whom we know. Every reader . . . has an acquaintance who secretly binges and purges" (p. 95). Students with eating disorders, particularly bulimia, may be Black or white, rich or poor, conformist or rebel, good student or dropout. At one extreme, students who appear to have nothing may want to be something, and slenderness is a ready badge of distinction and control. At the other extreme, the association between eating disorders and privilege is an important reminder that youngsters who appear to *have* everything can *feel* like nothing. This bitter contrast may make them even more susceptible to the devastating drive for control and thinness than those students from whom little is expected (6).

## References


1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder* (*DSM-III*). 3d ed. Washington, D.C.: APA, 1980.
2. Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia*. Baltimore: Johns Hopkins University Press, 1985.
3. Askevold, F. "Social Class and Psychosomatic Illness." *Psychother. Psychosom.* 38 (1982): 256–59.
4. _____. "The Diagnosis of Anorexia Nervosa." *International Journal of Eating Disorders* 2 (1983): 39–43.
5. Boskind-White, M., and White, W. C., Jr. *Bulimarexia: The Binge/Purge Cycle*. New York: W. W. Norton, 1983.

6. Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978.

7. Carter, J. A., and Duncan, P. A. "Binge-Eating and Vomiting: A Survey of a High School Population." *Psychology in the Schools* 21 (1984): 198–203.

8. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion*. New York: Doubleday, 1983.

9. Crowther, J. H.; Post, G.; and Zaynor, L. "The Prevalence of Bulimia and Binge-Eating in Adolescent Girls." *International Journal of Eating Disorders* 4 (1985): 29–42.

10. Eckert, E. D. "Characteristics of Anorexia Nervosa." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 3–28. Minneapolis: University of Minnesota Press, 1985.

11. Fairburn, C. G., and Cooper, P. J. "The Epidemiology of Bulimia Nervosa: Two Community Studies." *International Journal of Eating Disorders* 2 (1983): 61–67.

12. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.

13. Garner, D. M. "Sociocultural Issues in the Development of Eating Disorders." Paper presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.

14. Halmi, K. A.; Falk, J. R.; and Schwartz, E. "Binge-Eating and Vomiting: A Survey of a College Population." *Psychological Medicine* 11 (1981): 697–706.

15. Johnson, C., and others. "Incidence and Correlates of Bulimic Behavior in a Female High School Population." *Journal of Youth and Adolescence* 13 (1984): 15–26.

16. Johnson, C., and others. "A Survey of 509 Cases of Self-Reported Bulimia." In *Anorexia Nervosa: Recent Developments in Research*, edited by P. L. Darby and others, pp. 159–71. New York: A. R. Liss, 1983.

17. Kagan, D. M., and Squires, R. L. "Eating Disorders Among Adolescents: Patterns and Prevalence." *Adolescence* 19 (1984): 15–29.

18. Katzman, M. A.; Wolchik, S. A.; and Braver, S. L. "The Prevalence of Frequent Binge-Eating and Bulimia in a Nonclinical College Sample." *International Journal of Eating Disorders* 3 (1984): 53–62.

19. Leon, G. R., and others. "Binge-Eating and Associated Habit Patterns Within College Student and Identified Bulimic Populations." *International Journal of Eating Disorders* 4 (1985): 43–57.

20. Mitchell, J. E., and Pyle, R. L. "Characteristics of Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 29–47. Minneapolis: University of Minnesota Press, 1985.

21. Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*. New York: Van Nostrand Reinhold, 1983.

22. Pope, H. G., Jr., and Hudson, J. I. *New Hope for Binge Eaters: Advances in the Understanding and Treatment of Bulimia*. New York: Harper and Row, 1984.

23. Pope, H. G., Jr.; Hudson, J. I.; and Yurgelun-Todd, D. "Anorexia Nervosa and Bulimia Among 300 Suburban Women Shoppers." *American Journal of Psychiatry* 141 (1984): 292–94.

24. Pope, H. G., Jr., and others. "Prevalence of Anorexia Nervosa and Bulimia in Three Student Populations." *International Journal of Eating Disorders* 3 (1984): 45–51.

25. Pyle, R. L., and others. "The Incidence of Bulimia in Freshman College Students." *International Journal of Eating Disorders* 2 (1983): 75–85.

26. Sarason, I. G., and Sarason, B. R. *Abnormal Psychology: The Problem of Maladaptive Behavior*. 4th ed. Englewood Cliffs, N.J.: Prentice-Hall, 1984.

27. Schwartz, D. M.; Thompson, M. G.; and Johnson, C. L. "Anorexia Nervosa and Bulimia: The Sociocultural Context." *International Journal of Eating Disorders* 1 (1982): 20–36.

28. Stark, E. "Bulimia: Not Epidemic." *Psychology Today* 20 (January 1986): 17.

29. *Webster's New Collegiate Dictionary: 150th Anniversary Edition*. Springfield, Mass.: G. C. Merriam, 1981.

CHAPTER 7

# The Role of Culture in the Cause of Eating Disorders

Dr. Craig Johnson is a co-director of the Eating Disorders Program at Northwestern University's Institute of Psychiatry in Chicago. He has treated hundreds of bulimics and anorexics, most of whom are female. During his initial consultation with a bulimic, he usually asks whether she would relinquish the binge-purge cycles in exchange for a weight gain of 10 pounds. Although nearly three-quarters of these women are of low or normal weight, they regard his proposal with caustic dismay. Most flatly state that "they'd rather be *dead* than gain 10 pounds" (7).

What is responsible for this destructive equation of thinness with happiness and hope? How has fat, still a sign of prosperity and health in poorer countries, come to represent helplessness, ugliness, and immorality? What role do these equations play in the development of eating disorders? There are no simple answers to these questions, because research and clinical experience confirm that anorexia nervosa and bulimia must be understood as multidimensional outcomes of a transaction between biological constitution, family dynamics, personality, life circumstances, and culture (12, 19; and see Chapters 8, and 9 of this book).

Culture as a factor in eating disorders is a particularly important topic for all school employees interested in preventing eating disorders (13, 21, 22, 23). When we conceive of anorexia nervosa

and bulimia solely in terms of "mental illness" or "oral fixations" or "enmeshed families," there is a strong temptation to distance ourselves from them as "interesting" phenomena in the realm of psychiatry. If our society is somehow encouraging eating disorders, however, then teachers, staff, and students have the opportunity, if not the responsibility, to shift from inadvertent participation in a negative process to active elimination of pernicious attitudes, expectations, and practices.

## Boundaries of a Cultural Model

It is easy to speculate about the influence of culture. The fact that 95 percent of the people with eating disorders are young women strongly suggests that the meaning of femininity in modern Western society has something to do with the development of anorexia nervosa and bulimia. The association between eating disorders and socioeconomic privilege also points directly to the operation of social forces. From a historical perspective our society's obsession with thinness evokes numerous examples—Chinese footbinding, suffocating corsets with steel stays, pornography—of the culturally sanctioned oppression of women's bodies and minds (3, 12).

Our present lack of methodological sophistication and the scarcity of actual data make it possible to theorize about these and other cultural factors with little fear of contradiction. Thus, before considering the available research it is necessary to clarify the limits of a sociocultural theory of eating disorders.

Culture is but one of a number of interrelated influences. Consequently, culture cannot cause anything because it is manifested only through an interaction among differentially receptive individuals, their families, and their particular life circumstances (see Chapters 8 and 9). A cultural perspec-

tive begins with the simple but important fact that not all people exposed to the same set of overt cultural factors develop eating disorders. A substantial percentage of the women born between 1950 and 1960 have no "disorders," whereas large numbers suffer from other disabling problems such as depression and agoraphobia (29). We must also keep in mind that anorexia nervosa predates the industrial revolution; an excellent description of it dates from the seventeenth century (Morton, 1694, reproduced by Andersen [1]).

Another limitation is a significant degree of uncertainty about exactly what we are trying to explain. Is there one set of cultural factors for anorexia nervosa and a different set for bulimia? The answer depends on the relationship between the two disorders, and it is not known for certain if they are separate afflictions or different expressions of the same psychopathology.

This chapter assumes that anorexia nervosa and bulimia are not completely separate afflictions. Severe caloric restriction and binge-eating are frequently associated, and the transition between anorexia nervosa and bulimia can take place in either direction (35; and see Chapter 1). In addition, anorexics and bulimics share many characteristics (1; and see Chapters 8 and 9). The sufferers of both disorders are predominantly white females from the upper social classes. With both disorders there is an increased prevalence of depression, eating disorders, and weight problems in the immediate families. Finally, anorexics and bulimics share a drive for thinness, an intense fear of becoming fat, and a distorted body image.

The final constraint on efforts to specify the role of culture is the sheer number and variability of people with eating disorders (see Chapter 6). The extent to which a disorder affects a large number and wide variety of people is inversely proportional to the likelihood of a simple explanation of the ways in which culture or any factor influences that disorder. Coronary-prone (Type A) behavior is a

constellation of time urgency, runaway ambition, and cynical hostility that appears to characterize 40 to 60 percent of the white urban male population (28). Repeated failures to discover consistencies in the personalities, life stressors, and familial circumstances of Type A males have taught us that generalizations about widespread problems are necessarily elusive.

The stereotyping of bulimics and anorexics is misleading and imparts a false confidence about the direct role of cultural factors. But beyond this, the oversimplifications contained in the deluge of magazine articles, books, and films about eating disorders may themselves be a cultural contribution to the apparent upsurge during the past 10 years. Trumpeting phrases like "The Best Little Girl in the World" and "the golden girl syndrome," or reveling in the tale of Jane Fonda's battle against bulimia, the media inadvertently or sometimes purposely strengthen the association between eating disorders and culturally valued characteristics such as social status, intelligence, perfectionism, and self-control (16). In effect, a range of books, television dramas, and magazine articles have glamorized eating disorders, much as some Victorian observers came to associate a tubercular appearance or malady with artistic genius (12, 16).

## The Glorification of Thinness

### Can a Woman Be Too Thin?

The study of sociocultural factors in the development of eating disorders has been shaped in large part by Drs. Paul Garfinkel and David Garner of the University of Toronto (12, 14, 16). Their research makes it clear that the increase in eating disorders over the past 15 years coincides with a cultural glorification of thinness that has placed "intense pressure on women to diet in order

to conform to an unrealistic standard for feminine beauty" (16, p. 515).

The Duchess of Windsor is reputed to have said that "No woman can be too rich or too thin." Before dismissing this cliché with a smile, consider that each year the many thousands of visitors to Madame Tussaud's wax museum in London are asked to state their choice for the most beautiful woman in the world. In 1970 their favorite was the curvaceous Elizabeth Taylor. In 1974 a young model named Lesley Armstrong made the top five. At age 17 she stood 5'7" and weighed 97 pounds. By 1976, Lesley Armstrong, better known as "Twiggy," was number one (4, 31).

A variety of studies conducted since 1970 confirm that women perceive slenderness to be the most important aspect of physical attractiveness (16). Most teenage girls when asked about this issue will state that "guys like thin girls." This belief and its connection with body dissatisfaction were examined in a recent study at the University of Pennsylvania (10). A large number of male and female college students were shown two scales consisting of masculine and feminine outlines in gradations from thin to portly. The students then selected the points along these dimensions that best represented their current figure, their ideal, the figure most attractive to the opposite sex, and the shape of the opposite sex they found most attractive.

The results reveal just how deeply the worship of thinness has been implanted into women's minds. For males, the current, ideal, and attractive figures were nearly identical, and each was significantly more rounded than the average male figure preferred by women. That is, in general men misperceive the shape that appeals to women in a manner that reconciles it with their perception of their current shape and their ideal shape for themselves. It is very plausible that this "distortion" serves to maintain self-esteem (24).

For females, the pattern of ratings was very different. Roughly 65 percent felt them-

selves to be too heavy relative to their ideal and to the shape they believe men to prefer. This level of discontent is very similar to that reported by the 33,000 women who returned *Glamour Magazine*'s body image survey (11). On the average, the female physique preferred by a college man is indeed significantly thinner than a college woman's perception of her current physique. What a college woman thinks is attractive to men, however, is actually significantly thinner than the shape preferred by those men. Most important is the sad fact that the woman's ideal shape is even thinner than her misperception of the shape ideally attractive to men—in other words, it is the thinnest of all the ratings. This study leaves little doubt that, for college women at least, there is a significant internal need to become thinner, and that slenderness is much more than an issue of attractiveness to the opposite sex.

Intrigued by the shift in standards of beauty from Elizabeth Taylor to Lesley Armstrong, Garner and Garfinkel analyzed the measurements of *Playboy* magazine centerfolds and Miss America contestants from 1959 to 1978 (12). For the centerfolds there were statistically significant decreases in average bust and hip size accompanied by an increase in waist size. This trend toward a more tubular, Twiggy-like shape was also seen in Miss America contestants. The correlation between year and their percent of average weight for height was an astounding +0.83, a degree of relatedness that would occur by chance less than 1 time in 10,000. Further, since 1970 the winners of the pageant have weighed significantly less than the other contestants.

These data do not constitute regret over the abandonment of Elizabeth Taylor as an ideal of feminine beauty. In fact, I am reluctant to discuss body measurements at all, because there is a strong possibility that the sexual objectification of women in any form contributes to the identity diffusion, body dissatisfaction, obsession with dieting, and misplaced anger manifest in many people with eating disorders (3, 27, 39). Nevertheless, the

research just reviewed clearly supports the contention that over the past 20 years or so important segments of our culture have come to glorify thinness (3, 12). Even though correlation does not imply causality, it is at least thought-provoking that the emergence of Lesley Armstrong as a standard of beauty has paralleled both an absolute *increase* of approximately five pounds in the average weight of women under 30 and the emergence of eating disorders as a major health problem (12).

## The Media

How is the obsession with slenderness transmitted? Scanning through any popular magazine or watching TV for a few hours, it is easy to develop the conviction that the media assault us with outrageously thin models and preposterous advertisements whose claims for the restorative power of worthless or dangerous diets rival the cant of any "snake oil" salesperson (13). And the propaganda is by no means always so primitive. For example, in a recent series of articles about sociocultural factors in the development of eating disorders, the Cleveland *Plain Dealer* (October 6–8, 1985) included "10 Weight Loss Tips That Really Work," thereby undoing its own criticism of prejudice against obesity.

Despite my impressions and those of many experts (such as Bruch [6]), there has been surprisingly little systematic investigation of the media's contribution to the glorification of thinness. I came across only one study of television, which found that a mere 2 percent of the actresses on prime time were plump or overweight, and that thinness in actresses was positively correlated with a likable personality (Kurman, cited in Garner and others [14]). I admit that further research is necessary to convert impressions into facts, but I still find myself very concerned about the role of the media when—

1. I see pictures of Mary Decker Slaney and other

athletes who are extremely thin and extremely successful.

2. I see my first grader's cartoons interrupted by commercials for a product aimed at elementary school girls called "Get in Shape, Girl."
3. I stop by the newsstand at the supermarket and find *Slimmer: America's Fitness Magazine.*
4. I see the romanticizing of anorexic-like ballet dancers in the Cleveland *Plain Dealer* (August 2, 1985): "Moore, a painfully thin young dancer who looked as though she might float away at any moment, was perfectly cast as the ghostly Giselle. With her fragile body, huge eyes, pale face, and fluid arms, she created a touchingly poetic character who danced weightlessly and ultimately wafted into the wings like a zephyr" ("Friday Magazine," p. 4).

Women's magazines such as *Vogue* and *Seventeen* may be particularly influential in the glorification of thinness, although *Sports Illustrated*'s "Swimsuit Issue" certainly contributes to the objectification of women and to the reigning misbelief that to be fit is to be thin and vice versa (16). In a survey of five popular women's magazines, Garfinkel and Garner found that from 1970 to 1978 the number of feature articles on dieting was double that published in the previous decade (12). Anyone interested in eating disorders should find it disquieting that invariably these magazines offer an "anorexic" mix of thin models, articles about dieting and exercising, recipes for sweets, and numerous photographs of mouth-watering food in binge proportions.

## The Pursuit of Thinness

The worship of thinness can also be seen in attitudes toward overweight and the extent of people's involvement in weight control. If our culture is somehow setting the stage for eating disorders, we would expect that (1) negative atti-

tudes about overweight people would be common, (2) there would be widespread dissatisfaction with body weight and shape, (3) a large number of people would be intensely involved in dieting and weight control, and (4) the attitudes and practices of "normal dieters" would be similar to those of people with eating disorders. Before going any further, readers might carefully examine their immediate, "gut-level" answer to the following question: "Assuming I could make your choice magically come true, would you rather become more loving in your personal life, or would you rather lose 20 pounds from wherever you wish and keep it off?"

## Prejudice and Overweight

One night a skinny actress appearing on "The Tonight Show" said pointblank that fat people pollute the esthetic environment (36). This is prejudice, impure and simple.

Drs. Susan and O. Wayne Wooley, the directors of the Eating Disorders Clinic at the University of Cincinnati Medical Center, have reviewed a great deal of research that suggests that hostile attitudes toward overweight are widespread and deep-rooted (16, 36, 37, 38). Prospective parents rate a picture of a chubby child as less friendly, lazier, stupider, dirtier, and otherwise less desirable than pictures of a medium or thin child. Preschoolers prefer to play with a thin rag doll rather than a fat one, even though they cannot say why. By the second grade many children of both sexes and all weights are following in the footsteps of their parents; even the overweight children describe the silhouette of a fat child as "dirty," "lazy," "sloppy," "ugly," and "stupid."

The research with prospective parents makes it clear that most people do not outgrow this vicious stereotype. College students recommend a thin or medium person for a job over a fat one, even though all the applicants' performance of a task on videotape is identical. I am also ashamed to say

that, in the late 1960s at least, psychologists, physicians, and medical students did not differ significantly from elementary school children in judging fat people to be "slow," "unsuccessful," "weak," "passive (lazy)," "not nice," and "ugly" (16, 36).

The prejudice and ostracism that surround the overweight child undoubtedly influence later perceptions of self and others, particularly when they are reinforced by our cultural overemphasis on a woman's appearance (37, p. 82):

> The child whose build is socially "deviant" comes, early in life, to be regarded by others as responsible for his/her "condition," and deserving of social disapproval, and, sooner or later, is subjected to pressures to restrict food intake in order to "correct" his/her condition. Failure to do so is seen as "weakness," "wanting to be fat," or even as a masochistic desire for rejection.

Can there be any doubt that fat children internalize this hatred and rejection, and that children who are not fat learn to dread the prospect and significance of being overweight (37)? Hatred, rejection, ostracism—strong words, but words that clearly capture the emotional basis for arguing that in our culture the management of weight and shape is much more than a cosmetic or medical concern. In our culture avoiding fat is a moral issue (21, 39).

At this point many readers will find themselves resisting the implication that there is absolutely nothing wrong with being overweight. This is understandable. For at least two decades the medical and psychological communities have, with great authority, proclaimed that not only is being overweight a health hazard, it is a stigma of emotional disturbance. These beliefs are so ingrained in our cultural heritage that it seems foolhardy to challenge them. Nevertheless, they are false, and their perpetuation must be considered a way in which the helping professions, in collaboration with insurance companies and organizations such as the American Heart Association, contribute to eating disorders (2, 16, 37). Extreme obesity is potentially unhealthy, but mild-to-moderate obesity simply does not matter (except for the stress created by the reactions of the

individual or others). Epidemiological research indicates that within an 80-lb range—for example, 115–195 pounds for women 5'3" to 5'6"—there is no association between obesity and mortality. In fact, some studies have shown that, for certain ages, obesity is inversely related to mortality. Further, although 95 percent of those with eating disorders are women, the mortality rate for women is significantly less than that for men in all under- and overweight categories (2, 16, 37).

The contention that being overweight is a sign of psychological dysfunction is also contradicted by the preponderance of evidence. Garner notes that "most controlled studies do not find the obese to be more neurotic, sexually inadequate, or emotionally disturbed than individuals of normal weight. In fact some studies have found obese individuals to be less anxious, less depressed, and less prone to suicide than those of normal weight" (16, p. 522). It is true that many people characteristically overeat in response to stress, loneliness, or boredom (11). More and more evidence is accumulating, however, that this coping style is not the cause of obesity (16).

In summary, the physical risks and the psychological significance of being overweight have been greatly exaggerated. There are indeed problems associated with being overweight in our society, but these problems derive from the prejudice against obesity and the pressure on overweight people to diet (16, 36). Restrictive dieting is an ineffective long-term method of weight control, and it places one at risk for anorexia nervosa and bulimia (see Chapters 8 and 9).

## Body Dissatisfaction and Dieting

Consider the following recollection:

> One night, I gave myself permission to really splurge . . . I mixed it all: grease, cheese, and salt . . . I was sure I had gained. The next morning I could feel it as I rolled out of bed. When I looked in the mirror my hip bones had vanished . . . I was terrified. The whale that I had once

> been was looming. I inched onto the scale with dread and horror. With one eye shut, barely breathing, I looked down. Three numbers stared up at me—102; I had not gained an ounce! . . . I was overcome with joy and relief, and when I looked in the mirror again, my hip bones had reappeared. (36, p. 65)

Although this sounds like the diary of someone with an eating disorder, it is a selection from a best-selling diet book. Its publication marks "the first time an eating disorder—anorexia nervosa—has been marketed as a cure for obesity" (36, p. 57).

Every year numerous popular weight-loss regimens capitalize on our prejudice against obesity as they pander the thin body to otherwise intelligent readers seeking a magical solution to life's problems (13, 36). According to Wooley and Wooley, some of these programs are particularly pernicious because they glamorize dieting while blithely encouraging readers to plan binges and compensations—fasts, days restricted to eating only one food, foods designed to induce diarrhea, and manipulations of water retention instead of body fat (36). The popularity of the weight-loss genre is a tragic testament to the willingness of millions of Americans to reject themselves and embrace the primitive but seductive equations that constitute the foundation of the diet-exercise industry: dieting = slenderness = goodness; eating normally = fat = badness. The popularity of some diet regimens only serves to increase the risk of eating disorders by perpetuating "the prevailing belief . . . that nothing is worse than being fat; that no price is too high for thinness, including health" (36, p. 65).

In 1978 a Nielsen survey revealed that 55 to 60 percent of all women ages 24 to 54 diet, and of that group three-quarters acknowledge doing so in order to look better rather than to feel better (30). Similarly, 42 percent of the 33,000 women who completed *Glamour Magazine*'s body image survey said losing weight would make them happier than "success at work," or "a date with a man you admire" (11). Moreover, a full three-quarters of these respondents considered themselves too

fat, including 45 percent of those who were underweight. The pressure these women feel to diet is captured succinctly by the startling fact that two-thirds of the ***underweight*** women "often want to diet because they feel fat."

Studies conducted during the 1960s revealed that 50 to 80 percent of high school girls in the United States, England, and Sweden had dieted at some time because they considered themselves overweight, even though only half of them were too heavy according to standardized measures (14, 20). To update this research John Kelly and Sonia Patten of the University of Minnesota recently surveyed nearly 2,000 boys and girls from 12 suburban high schools serving predominantly white and middle- to upper-middle-class students (20). This investigation focused on the attitudes and weight management practices of the 85 percent who were considered neither too thin nor too fat because their weight "fell between the 85th and 114th percent of standard weight for height and age" (p. 194).

Kelly and Patten found that a large percentage of normal-weight teenagers, particularly girls, were dissatisfied with their weight and/or concerned about being overweight. Around 40 percent of the boys and girls wanted to lose weight, but a closer analysis indicates that this parity is illusory. In general the boys *wanted* to reduce so that they could be more successful in competitive sports, but they were unlikely to translate their desire into either dieting or exercising with the intention of losing weight.

On the other hand, the figure of 40 percent probably underestimates the percentage of girls who were concerned about their weight and trying to lose weight. A majority of the girls—none of whom was technically overweight—were "frequently" or "constantly" concerned about being overweight (69 percent), wanted to be "very thin" (59 percent), liked losing weight (68 percent), and got angry with themselves after overeating (69 percent). Just under half of these girls were currently dieting with the express intent of losing weight and

increasing their attractiveness, which they see as less than that of their female peers. The extent to which the glorification of thinness has influenced today's teenage girls is seen in the fact that not a single one whose actual weight was between 95 to 115 percent of the standard for her height and age endorsed the item "I feel more attractive than most other people."

Kelly and Patten's research suggests that, at any given time, at least 40 percent of all white, middle-class, *normal-weight* girls attending suburban high schools are actively engaged in losing weight in order to become very thin. Of equal importance is the finding that for girls, but not boys, slenderness was positively correlated with higher grades, more friends, and a greater interest in dating. This raises the disturbing possibility that, as a result of cultural messages equating thinness with beauty and virtue, slenderness is actually becoming a significant characteristic in the development of feminine self-concept and self-esteem (20, 39).

If slenderness has indeed moved from the category of a magical solution to a real asset, then there exists a double jeopardy that is bound to place more and more young girls at risk for eating disorders (20). On the one hand, girls who do not wish to be thin or who are genetically incapable of it will be actively discouraged from feeling good about their bodies and themselves. On the other hand, the vast majority of those who buy into this new "American dream"—slenderness—will be continually fighting the dictates of their biological constitution, the abundance of both nutritious and nonnutritious food, and the cleverness of professionals who earn a lot of money advertising pizza, beer, hamburgers, and candy. The dieter who sees no choice but to reduce may or may not become and remain thin (and the odds are very much against both), but either way the cost of rigorous dieting will be very high—a perpetual hunger for food and unconditional positive regard, indulgence in dangerous weight-control practices, an unstable self-image, a constant war with the self and others over the

issue of control, and disillusionment upon discovering that in the long run self-denial is no more a solution to life's complexities than indulgence (16, 20).

## Eating Disorders and Normal Weight Control

The fact that weight anxiety, body dissatisfaction, dieting, and dangerous weight-control practices (see Chapter 6) occur with great frequency among high school and college students raises the possibility that anorexia nervosa and bulimia lie at the extreme end of a culturally supported continuum of maladaptive beliefs and behaviors. To test this hypothesis Garner devised the Eating Disorders Inventory or EDI (14, 15). The 64 items on this questionnaire cluster into eight behaviors and attitudes present in most cases of anorexia nervosa and bulimia. These are a drive for thinness, engagement in binge-eating and self-induced vomiting, body dissatisfaction, perfectionism, a sense of personal ineffectiveness, interpersonal distrust, disturbances of interoceptive awareness (see Chapter 2, pp. 43–44), and fears of maturity.

Garner and his associates administered the EDI to anorexic patients and to a large group of female undergraduates. Based on their responses, the students were grouped into those who were weight-preoccupied and those who were not. As dictated by the EDI's standardization, the anorexics' scores on all eight subscales were significantly greater than those of the non-weight-preoccupied students. The weight-preoccupied students, however, were very comparable to the anorexics in their high levels of drive for thinness, body dissatisfaction, and perfectionism. Anorexics appear to have some unique psychological problems (such as mistrust and maturity fears), but the fact that they share several salient features of their disorder with normal female undergraduates provides support for the role of culture in the development of this form of psychopathology (14, 34).

# The Relentless Pursuit of Thinness

During one of my all-too-rare visits to the college athletic complex for an afternoon workout, I happened across two sheets of paper in an empty locker. These pages from *The Runner* magazine (25) invited me to rate my "running commitment" on a scale adapted from a popular book, *In Pursuit of Excellence*. As a sedentary psychologist interested in eating disorders, I read all the questions, but replaced each "running" or "excelling" with "losing weight" or "staying thin."

I was disturbed by the fit between these substitutions and the attitudes manifested in anorexia nervosa and bulimia. People with eating disorders are extremely "willing to sacrifice other things to excell in [staying thin]." They "never let up or give up in a race [to lose weight]." They also "push hard even when it hurts." Further, they "feel more committed to improvement in [losing weight or staying thin] than anything else" and "they feel more successful or gain more recognition in [losing weight or staying thin] than anything else."

I believe that the glorification of fanatical self-control increases the danger inherent in our culture's idealization of thinness. Many dieters, dedicated to the pursuit of thinness despite their genetic heritage and in the face of constant temptation, see their bodies as the "enemy" (11, 34). As demonstrated previously, quite often the goal of this battle with biology is self-control, not improved health or even heightened sexual attractiveness. For centuries, fasting in the presence of plenty has signified a distinctive purification of the soul (9, 14). The goal for many of today's dieters is to be similarly virtuous and special through the exercise of fanatical self-denial (see Chapter 3). Now that the standard of living in Western culture is higher for all classes, body fat is no longer a sign of wealth or power. On the contrary, being thin has become a symbol of uncommon beauty and goodness, as well

as a sign of youth in a culture that does not respect the elderly (3, 39). The negative correlation between obesity and social class highlights all too clearly the positive correlation between eating disorders and socioeconomic privilege (14).

Many people will angrily resist the implication that there is anything wrong with sacrificing "everything" in order to be the best. Competitive ambition and perfectionism are highly valued commodities in our male-dominated, achievement-oriented society (28). Moreover, in a culture such as ours, where external restraints on behavior are lessened or at least muddled, there is often open admiration for those who struggle against great odds to blend self-control and achievement (14).

A striking example is our reverence of triathletes. In one sense these men and women are highly skilled athletes dedicated to peak physical and mental conditioning. The successful triathlete, however, is often a person who sacrifices relationships and a multidimensional life in order to achieve recognition and, in some cases, riches through an "all-consuming" devotion to exercising, eating huge quantities of food, and obsessing about diet, appearance, and competition. To an impressionable youngster the positive significance of the triathlon may be superseded by a more primitive message that supports both an egocentric desire for uniqueness and the seductive suggestion that one can eat huge quantities of food as long as one balances it out with fanatical exercise.

To investigate the dangers posed by a combination of fanaticism, competition, and pressures for a thin body, Garfinkel and Garner administered the Eating Attitudes Test (EAT) to female students at three different professional ballet schools, a professional modeling school, a Canadian university, and a music conservatory (12). The music students were evaluated because their training is intensely competitive, but they are under no apparent pressure to be thin as they perform. The EAT is similar in structure to the EDI, but focuses more on

specific aspects of anorexia nervosa such as extremely restrictive dieting, food preoccupation, and internal versus external control of eating (12).

The results of this study clearly demonstrate that circumstances emphasizing dedication, competition, and pressure for thinness foster anorexia nervosa and anorexic attitudes. Twelve of the 183 (6.5 percent) professional dance students met the *DSM-III* criteria for anorexia nervosa (see Chapter 6, Table 6–1). Another 26 (14 percent) of the dancers were not technically "anorexic," but they did report a "drive for thinness" and a "morbid fear of weight gain" equivalent to those of hospitalized anorexics. In addition, this subgroup reported frequent use of self-induced vomiting and laxatives to control their weight. In general, the dance and modeling students had significantly higher scores on the EAT than the female undergraduates and professional music students, and the dancers from more competitive programs had the highest scores. This correlation and the low scores of the music students indicate that dedication and competition do not cause eating disorders. They become sinister only when coupled with explicit pressures to remain thin.

## Eating Disorders and the Psychology of Women

The observation that 1 to 5 percent of bulimics and anorexics are male means that it is a serious mistake for school staff, students, and professionals to classify eating disorders as a "women's issue" (1; and see Chapter 6). Nonetheless, the fact remains that 95 percent of those who admit to having an eating disorder or present themselves for treatment are female. At present the relationship between eating disorders and feminine biology or sex-role identity remains unclear; anorexia nervosa and bulimia have been variously associated with a rejection of femininity (9), a confused acceptance of femininity (4), and a rebellious redefinition of femi-

ninity (27). These discrepancies in theory should not, however, obscure the obvious: the extreme sex difference in the prevalence of eating disorders means that the nature of femininity in our culture is a significant risk factor in the development of anorexia nervosa and bulimia. (See Streigel-Moore, Silberstein, and Rodin [33] for an extensive discussion of the relationship between eating disorders and many issues in the psychology of femininity—for example, the connections among physical attractiveness, pleasing and serving others, and self-esteem.)

The astute, as well as the cynical, observer will note that the emergence of eating disorders as a widespread problem coincides with the expansion of the feminist movement (18, 31). This in no way means that feminism "causes" eating disorders; Lincoln's emancipation proclamation is certainly not to blame for the economic plight of millions of poor Blacks in the United States. Rather, the association between the feminist movement and eating disorders may indicate that "if one lives in a culture where the roles of women are complex, conflicting, and in change, and if these pressures exist in a milieu which emphasizes a high positive value on slimness and negative value on obesity, one is at greater risk for anorexia [and bulimia]" (31, p. 87).

In their book, *Bulimarexia: The Binge/Purge Cycle* (4), Marlene Boskind-White and her husband William describe their therapeutic work with female bulimics from Cornell University and other colleges around the country. In general, these young women are bright, energetic, talented, interesting, and privileged. But this potential only seems to contribute to a strong feeling of being trapped between a dedication to traditional feminine values and an overpowering sense that they *must* compete with men and women in developing a successful career. Janice Cauwels, author of another highly recommended book, *Bulimia: The Binge-Purge Compulsion* (7), is convinced that these women and our society in general have misperceived the feminist emphasis on opportunity and choices for women as

an obligation to achieve professional success at an early age.

In my opinion many men and women are extremely threatened by attempts to expand the gender identities of both sexes in the direction of greater depth and freedom. Consequently, to maintain the balance of power in favor of men or some vague conception of the status quo, this resistant majority has perverted the feminist demands for equality of opportunity into an unrealistic insistence that women reconcile the traditional and contradictory masculine and feminine roles into a "super" identity (3, 7). This identity retains many features of the established feminine role—for example, an obsession with the body, sensitivity to others, and dependence on male approval—but redefines the substance and style of femininity to emphasize thinness, youth, ambition, self-control, and self-sufficiency (3). Ironically, radical feminists may be adding to this diffused identity by rejecting those women who *choose* to delay or even eschew a career in favor of the traditional homemaker role.

It is likely that rejection of the stereotypical feminine role with its images of a soft, rounded, and self-effacing mother contributes in some way to our cultural obsession with thinness (14). The other side of this new coin may be the need to look younger and more masculine—that is, thinner—in order to compete and gain respect in the essentially masculine world of business. Or both motives can be condensed into a single need—to compete with other women over who is the thinnest and most virtuous at the dinner table (7). A cigarette continually reminds women that they have "come a long way, *baby*" (italics added) in their quest for social and economic autonomy. This cigarette is not called "Virginia Fats." The painful irony here is that the commercialization of thinness is actually a means of "cashing in on women's gullibility, self-consciousness, uncertainty, and anxiety" (3, p. 123). The new, slender style is not a true symbol of liberation, but simply a newer badge of subjugation, this time to a

god of thinness that is much more dangerous than whalebone corsets or stiletto heels (3, 13).

Arguing from a historical and a clinical perspective, Boskind-White and the Wooleys make a convincing case that the relentless pursuit of thinness is embedded within a broader and very complex cultural issue, the expansion and diffusion of the feminine sex role (3, 39). This hypothesis was examined in a recent study by Dr. Catherine Steiner-Adair of the Children's Hospital Medical Center in Boston (32). The subjects of her research were 32 girls attending a private high school—a group at risk for eating disorders (see Chapter 6). Steiner-Adair found that all the girls were quite aware of the "superwoman" ideal. Each was able to describe her as *thin*, attractive, smart, active, independent, autonomous and dominant within relationships, and somehow *perfectly* successful in establishing a career, being an exciting wife, and raising a family. Nineteen (60 percent) of the girls seemed to understand that pursuing this myth would jeopardize the sense of interpersonal connectedness around which girls, as opposed to boys, tend to build their identities (17). The remaining 13 girls (40 percent) wholeheartedly embraced this contradictory vision of interdependent autonomy, seeing no internal inconsistencies and no dissonance between the intense pressure to be separate versus their socialization to value relationship above complete individuation. Of the girls who saw through the superwoman myth and rejected it, not one had an EAT score in the eating disorder range. Of the girls who identified with the superwoman, 11 (85 percent) had scores in the eating disorder range and another was borderline.

It may well be that the bulimic college women who participate in Dr. Boskind-White's therapy groups are at a later stage of the doomed struggle to become superwomen. The ambiguous and conflicting pressures created by separation from men and reliance on their approval leave these women feeling "empty" (= hungry?), out of control, and angry (4). In this regard, dieting, bingeing, and purging can be construed as counterbalanced and

culturally legitimate means of aspiring to the ideal of thinness while combating such disruptive feelings.

The work of Boskind-White and Steiner-Adair provides strong support for the belief that complex transformations in the feminine role constitute a sociocultural factor in the proliferation of eating disorders. The key feature here is change itself; it is a serious mistake, as well as a great injustice to women and men, to interpret the research on sex roles as suggesting that girls would be better off if only they would accept the traditional feminine characteristics. The ability of the fashion and diet industries to inculcate the goal of thinness is based squarely on the traditional feminine identification of self-esteem with personal appearance (3, 39). Moreover, research conducted in the 1970s demonstrated that male and female psychologists listed the same ideal characteristics for a healthy "person" and a healthy "male," whereas their conception of a mature female was antithetical to their description of a healthy "person" (5)! We certainly do not need to return to a lopsided feminine sex role whose actualization moves one in the direction of psychological disturbance (8).

A recent survey of women attending Miami University in Ohio suggests that changes in both the feminine sex role and the ideal body shape form a cultural backdrop for the proliferation of eating disorders (Debs and others, cited in Wooley and Wooley [39]). Although most of the women believed their mothers to be generally approving of them, only 43 percent felt the mother's attitude toward the daughter's body was at least "mostly positive." More important, the degree of this perceived negativity was highly correlated with all but one of the EDI subscales. Body dissatisfaction was the strongest predictor of bulimic behavior, but the next strongest was the daughter's perception that her mother was very critical of the daughter's body. This is very interesting in light of two findings of the *Glamour Magazine* survey (11). First, very few of today's women feel that their mothers like their own

bodies. Second, a woman's negative attitude toward her own body is highly correlated with the perception that both mother and father are or were critical of her body shape.

Assembling these correlations into a dynamic portrait of familial interactions is difficult, but the Wooleys offer a thought-provoking and plausible interpretation (39). They note that the mothers of today's teenage girls are the first cohort of women to experience generalized dissatisfaction with their weight and themselves as a result of fashion propaganda, the changing roles of women, and our culture's increasing emphasis on youth (see also Boskind-White [3]). It is hard to see how this lack of respect for body and self would not color the development of their daughters in some important ways. When these girls reach puberty, or even before, their body shape may become a projective surface for the mother's unfulfilled wishes and uncertainties and for the daughter's needs to act like a woman (mother) while becoming her own, "better" woman (not mother). In this emotionally charged interaction, "dieting may serve simultaneously as identification, differentiation, revenge, and penance" (39, p. 392). The pain of this conflict and confusion is great, but not as great as that involved in rejecting the female role. Perhaps the hostile purification of the anorexic and the uncontrollable gorging and purging of the bulimic represent a culturally supported lack of respect for the normal female body and a need to escape the choices posed by the dilemma of maternal versus paternal identification (39).

The role of hostility, expressed outwardly as anger and inwardly as self-loathing, in the development and expression of eating disorders is deserving of more research. The proliferation of eating disorders has coincided, not only with feminism and increasing pressures for thinness, but also with an explosion of violence against women in the streets, in the home, on film, and in "literature." Surely such denigration does nothing to help girls and women learn to respect their bodies and themselves. In addition, women are socialized to deny

anger or keep it to themselves (3, 17). Both these factors increase the likelihood that eating disorders are in part self-directed expressions of rage that also serve to mock the very same dependency, objectification, and idealization of thinness that many anorexics and bulimics cannot refrain from embodying.

## History, Culture, and Psychopathology

Sociocultural theories of psychopathology maintain that culture shapes the nature of anxiety and the means by which people cope with inner turmoil. The classic illustration of this principle is the conversion hysteria that afflicted a number of middle- and upper-class women in England and Western Europe at the close of the Victorian era (26, 31). In response to overwhelming life stress these women unconsciously converted deep-rooted conflicts between internal urges (such as sexuality and anger) and external proprieties (being "feminine") into an apparent physical disorder (hysterical paralysis). This strategy protected the person and others from the power and significance of the emotional conflict. However, the conversion also permitted some satisfaction of the urges (through attention, massage, and passive aggression), while enabling the individual to retain the feminine qualities of helplessness and dependency (she "couldn't stand on her own two feet").

Eating disorders may well be the conversion disorders of our times (31). As our culture has changed, so have our anxieties, proprieties, and coping strategies. But now many vulnerable people—young women—convert powerful new conflicts between internal needs (to "be in control" and to "be someone") and external proprieties ("being thin" and "feminine") into eating disorders. Anorexia nervosa and bulimia reconcile both these pressures before they devolve into a dangerous parody of each.

# Conclusions and Implications

## The Role of Culture

*Conclusion.* It is difficult to establish the influence of culture on psychopathology. Nevertheless, the evidence reviewed in this chapter leaves little doubt that sociocultural factors are encouraging the development of eating disorders. Of special significance in this respect is the finding that a large number of people in our culture, particularly teenage girls, manifest many of the psychological characteristics and weight control practices that form the basis of anorexia nervosa and bulimia.

*Implication.* All school employees who wish to transform the school into a positive force in the prevention of eating disorders must acknowledge that people with eating disorders are not "crazies" who fall prey to an incomprehensible "mental illness." Rather, they are people—our students, our children, our colleagues, and our friends—struggling with insecurities and pressures that we as members of our culture have helped create or sustain.

## The Glorification of Thinness and Rigid Self-Control

*Conclusion.* The increase in the prevalence of eating disorders is in part attributable to the emergence of thinness as an ideal of feminine beauty and as a concrete expression of virtuous self-control. A drive for thinness is arguably the most important feature of both anorexia nervosa and bulimia. This motive is reinforced by a host of cultural messages: the ultra-thin models of a high-class fashion magazine like *Vogue*, a coach's misguided advice to "come back after you've lost some weight," a cigarette called "More" that features a

thin woman clad in an expensive outfit. The dark side of this culturally supported drive for thinness is widespread prejudice toward overweight individuals, particularly women. In this context weight loss and slenderness have become standards of beauty and goodness. There is little evidence that the health of Americans has benefited from these values, but there is substantial evidence of widespread dissatisfaction with natural body shapes and of intense pressure to challenge normal weight by restrictive dieting. For certain vulnerable individuals, the long-term outcome of this anxious self-rejection is an eating disorder (see Chapters 8 and 9).

*Implications.* The glorification of thinness and fanatical self-control illuminates the many obstacles faced by school staff interested in the prevention of eating disorders. First, there is the challenge of examining one's own beliefs and behaviors for evidence of a psychological investment in slenderness and/or prejudice against overweight. At the very least educators should try to eliminate negative statements about overweight people from their language and other educational tools. Second, the fusion of slenderness with beauty and virtue means that body weight, body shape, and attractiveness will be very sensitive issues for discussion within a mixed-sex group that probably includes several overweight students and numerous dieters (21). And third, examination of the totally unwarranted prejudice against overweight and even normal-weight people will likely conclude with sound but controversial contentions—for example, most people should not eat less than 2,000 well-balanced calories per day (see Chapter 9) and the definition of healthy body weight should depend on the person's function and fitness, not on a table of heights and weights that overlooks vast individual differences in "natural" body weight (16).

This list of challenges is not meant to discourage consideration of sociocultural factors in the development of eating disorders. Far from it. My intent is rather to encourage careful preparation for

discussion of some of the most important factors in the cause of anorexia nervosa and bulimia: prejudice, the media, fashions, competitive ambitiousness, sex differences, the biological regulation of eating and weight, and the normalization of excessive dieting (see Chapter 10). This rich variety of topics makes the influence of sociocultural factors a fertile ground for teachers of social studies, history, speech, home economics, health science, and biology (21).

## Eating Disorders and the Changing Feminine Sex Role

*Conclusion.* Three facts clearly connect eating disorders with changes in the feminine sex role. First, the upsurge of eating disorders coincides with the increased impact of the feminist movement and the resultant expansion of the feminine sex role to include contradictory demands for autonomous and interdependent behaviors. Second, most anorexics and bulimics are females who develop their eating disorders during adolescence, a time of life in which the issues of identity and intimacy are paramount in personal development. Third, the research by Steiner-Adair demonstrates a correlation between identification with the "super-thin superwoman" ideal and anorexic-like attitudes and behaviors. At present we do not know how these confusing and oppressive changes in the feminine sex role combine with the traditional feminine investment in personal appearance to set the stage for eating disorders. It is very likely, however, that the relentless pursuit of thinness reflects numerous themes, including identification with current ideals of youthful beauty, rejection of traditional feminine shapes and limitations, and the struggle for control of something concrete—weight and shape—in a world of abstract ambiguities (6, 27, 39).

*Implications.* As noted earlier, educators interested in eating disorders must deal carefully and sensitively with the emotional topics of body weight, body shape, and body image. Self-conscious

teenagers, in particular, find it difficult to discuss openly these fundamental aspects of what is often an incomplete self-concept. This challenge to teachers is intensified by the fact that these topics have a different meaning for girls and boys. The entire notion of a sex role is tricky, because it blurs individual differences, emphasizes constraints on personal freedom, and points to gender inequities. Nevertheless, consideration of cultural expectations for males and females is necessary if two crucial questions are to be addressed: Why do people diet? (see Levine [21]) and Why do more girls than boys diet? Given the emotional nature of these questions, they might be best addressed initially through nonthreatening assignments such as the collection and analysis of boys (men) and girls (women) as portrayed in a variety of advertisements.

## A Sociocultural Approach to Prevention

*Conclusion.* The multidimensional nature of eating disorders, as well as their history of at least 300 years, suggests that even radical changes in Western culture are not likely to eliminate anorexia nervosa and bulimia completely. Nonetheless, if culture shapes the nature of our fears and our strategies for coping with them, then the school as an influential representative of society can play an important role in combating many of the constituents of eating disorders, such as the inflexible need to be thin, the normalization of dieting, and the glorification of competitive self-control.

*Implication.* The role of the school in socialization is controversial, but one of the bases of this book is my conviction that, through education and personal example, teachers can promote a healthy acceptance of self and others by actively resisting cultural pressures to equate thinness with fulfillment, perfectionism with virtue, and opportunity with obligation. Not all teachers will have the

inclination or time to become involved in the prevention of eating disorders. Those who choose to must join with counselors and other school staff, parents, and students in resisting the strong temptation to dissociate themselves from eating disorders by marveling at their bizarre signs and symptoms, giving them impressive psychiatric labels, and then turning over all responsibility for comprehending, identifying, and preventing them to experts (21, 22).

## References


1. Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia*. Baltimore: Johns Hopkins University Press, 1985.
2. Bennett, W. G., and Gurin, J. *The Dieter's Dilemma: Eating Less and Weighing More*. New York: Basic Books, 1982.
3. Boskind-White, M. "Bulimarexia: A Sociocultural Perspective." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 113–26. New York: Brunner/Mazel, 1985.
4. Boskind-White, M., and White, W. C., Jr. *Bulimarexia: The Binge/Purge Cycle*. New York: W. W. Norton, 1983.
5. Broverman, I., and others. "Sex-Role Stereotypes: A Current Appraisal." *Journal of Social Issues* 28 (1972): 59–78.
6. Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978.
7. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion*. New York: Doubleday, 1983.
8. Chesler, P. *Women and Madness*. New York: Avon Books, 1973.
9. Crisp, A. H. *Anorexia Nervosa: Let Me Be*. London: Academic Press, 1980.
10. Fallon, A. E., and Rozin, P. "Sex Differences in Perceptions of Desirable Body Shape." *Journal of Abnormal Psychology* 94 (1985): 102–5.
11. "Feeling Fat in a Thin Society." *Glamour Magazine* (February 1984): 198–201, 251–52.
12. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.

13. Garner, D. M. "Sociocultural Issues in the Development of Eating Disorders." Paper presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.

14. Garner, D. M.; Garfinkel, P. E.; and Olmsted, M. P. "An Overview of Sociocultural Factors in the Development of Anorexia Nervosa." In *Anorexia Nervosa: Recent Developments in Research*, edited by P. L. Darby and others, pp. 65–82. New York: A. R. Liss, 1983.

15. Garner, D. M.; Olmsted, M. P.; and Polivy, J. "The Eating Disorders Inventory: A Measure of Cognitive-Behavioral Dimensions of Anorexia Nervosa and Bulimia." In *Anorexia Nervosa: Recent Developments in Research*, edited by P. L. Darby and others, pp. 173–84. New York: A. R. Liss, 1983.

16. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.

17. Gilligan, C. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press, 1982.

18. Johnson, C. "Biopsychosocial Model of Etiology for Bulimia." Paper presented at Third National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1984.

19. Johnson, C., and Maddi, K. L. "The Etiology of Bulimia: Bio-Psycho-Social Perspectives." *Annals of Adolescent Psychiatry* 13 (1986): 253–73.

20. Kelly, J. T., and Patten, S. E. "Adolescent Behaviors and Attitudes Toward Weight and Eating." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 191–204. Minneapolis: University of Minnesota Press, 1985.

21. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

22. _____. "The Role of Culture in the Cause of Eating Disorders." *Kenyon College Alumni Magazine* 9 (Winter 1985): 8–13. Available from Michael Levine, Psychology Department, Kenyon College, Gambier, OH 43022 (614–427–2244).

23. _____. "Whatever Happened to Lesley Armstrong? The Role of Culture in the Cause and Prevention of Eating Disorders." Workshop presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.

24. Lewinsohn, P. M., and others. "Social Competence and Depression: The Role of Illusory Self-Perceptions." *Journal of Abnormal Psychology* 89 (1980): 203–12.

25. Lynch, J. "Commitment: What You Give Is What You Get (Better Running)." *Runner* (December 1984): 20–21.

26. Monte, C. *Beneath the Mask: An Introduction to Theories of Personality*. 2d ed. New York: Holt, Rinehart and Winston, 1980.

27. Orbach, S. "Visibility/Invisibility: Social Consideration in Anorexia Nervosa—A Feminist Perspective." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 127–38. New York: Brunner/Mazel, 1985.

28. Price, V. A. *Type A Behavior Pattern: A Model for Research and Practice*. New York: Academic Press, 1982.

29. Rosenhan, D. L., and Seligman, M. E. P. *Abnormal Psychology*. New York: W. W. Norton, 1984.

30. Schwartz, D. M.; Thompson, M. G.; and Johnson, C. "Anorexia Nervosa and Bulimia: The Sociocultural Context." *International Journal of Eating Disorders* 1 (1982): 20–36.

31. Schwartz, D. M.; Thompson, M. G.; and Johnson, C. "Eating Disorders and the Culture." In *Anorexia Nervosa: Recent Developments in Research*, edited by P. L. Darby and others, pp. 83–94. New York: A. R. Liss, 1983.

32. Steiner-Adair, C. "The Body Politic: Normal Female Adolescent Development and the Development of Eating Disorders." Paper presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.

33. Streigel-Moore, R. H.; Silberstein, L. R.; and Rodin, J. "Toward an Understanding of Risk Factors for Bulimia." *American Psychologist* 41 (1986): 246–63.

34. Thompson, M. G., and Schwartz, D. M. "Life Adjustment of Women with Anorexia Nervosa and Anorexic-Like Behavior." *International Journal of Eating Disorders* 2 (1981): 47–60.

35. Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.

36. Wooley, O. W., and Wooley, S. C. "The Beverly Hills Eating Disorder: The Mass Marketing of Anorexia Nervosa" (editorial). *International Journal of Eating Disorders* 1 (1982): 57–69.

37. Wooley, O. W.; Wooley, S. C.; and Dyrenforth, S. R. "Obesity and Women—II. A Neglected Feminist Topic." *Women's Studies International Quarterly* 2 (1979): 81–92.

38. Wooley, S. C., and Wooley, O. W. "Obesity and Women—I. A Closer Look at the Facts." *Women's Studies International Quarterly* 2 (1979): 69–79.

39. Wooley, S. C., and Wooley, O. W. "Intensive Outpatient and Residential Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 391–430. New York: Guilford Press, 1985.

CHAPTER 8

# The Causes of Anorexia Nervosa: A Multidimensional Perspective

The clinical features of anorexia nervosa differ substantially from case to case. Moreover, each case is the product of many complex and interacting factors, none of which is necessary or sufficient for the disorder to emerge (2, 11, 32, 34). This is a perplexing state of affairs for researchers, therapists, families, teachers, and authors alike. Variability and multidimensionality mean that there is no single, comfortable "cause" of anorexia nervosa, and that there will be differing sets of causes for different anorexics; if you will, there are different access roads to a multilane highway called anorexia nervosa. Most important, a multidimensional perspective encourages us to stop looking for direct causes and start identifying the factors that place a person "at risk." The more of these factors that are present, the greater the risk of developing this eating disorder.

## The Three P's

Risk factors can be divided into *predispositions* and *precipitants* (11). Predispositions constitute the vulnerability for disorder, while precipitants are those personal practices and external stressors that transform vulnerability into an awful reality (28). In other words, the predisposing factors determine the appearance of anorexia nervosa instead of healthy adjustment or another psychological

problem, while the precipitants account for the emergence of the eating disorder at a particular time (12). There are also *perpetuators*, effects of the disorder itself that entrench or worsen the illness over time. In short, a model of anorexia nervosa must consider the three "p's": predispositions, precipitants, and perpetuators (16).

## Biological Predispositions

### Genetics

Determining the heritability of normal and abnormal behavior in humans is challenging and controversial under the best of circumstances, and the behavior genetics of eating disorders lags far behind comparable investigations of depression and schizophrenia (27). Nonetheless, based on the following findings, there seems to be a hereditary factor in anorexia nervosa (see reviews by Eckert [10], Garfinkel and Garner [11], Yager [34]).

#### *Risk in Family Members*

Although it is rare for the mothers of anorexic girls to be anorexic, 15 to 25 percent of first-degree relatives (mothers *and* fathers, sisters *and* brothers) report unusually low adolescent body weights, as well as anorexic-like behaviors and attitudes toward eating. Further, the risk of full-blown anorexia nervosa in the sisters of anorexic patients is 3 to 10 percent compared with a rate of 1 percent or less in the general population of postpubertal females (see Chapter 6).

#### *Twins*

Monozygotic (identical) twins have exactly the same genetic composition, whereas dizygotic (fraternal) twins are no more alike genetically than any other sibling pair (50 percent similar). If

anorexia nervosa has a genetic basis, then the probability of identical twins being anorexic should be significantly greater than the probability of concordance for fraternal twins. Based on less than 50 sets of twins (too small a number for scientific confidence), it appears that the concordance rate for monozygotic twins is approximately 50 percent. The rate for dizygotic twins is around 10 percent—that is, the rate for non-twin siblings.

### *Familial Vulnerability*

The first-degree relatives of anorexics are unusually vulnerable to stress-related disorders (such as gastritis and peptic ulcer) and to affective disorders (such as depression and mania). In fact, the abnormally high rate of depression and alcoholism in the family histories of anorexics is comparable to that observed in the families of patients with major depressive disorders (18). Interestingly, the connection between alcohol addiction in the fathers and anorexia nervosa in the daughters is particularly strong for the subgroup of anorexics who binge-eat and purge.

The familial vulnerability to a spectrum of psychological disorders suggests that anorexics do not inherit a specific predisposition for anorexia nervosa. Instead, they may inherit a general vulnerability to emotional disruption and overreactions to stress, proclivities that later take a specific form based on gender, sociocultural factors, and family dynamics.

### *Conclusion*

Collectively, the evidence for a genetic component in anorexia nervosa is impressive but not definitive. The same data could be marshaled in service of the theory that growing up as an identical twin or in a family with one or more disturbed members makes it difficult to form an identity based on internal strengths rather than external images of

thinness (11). Since most anorexics come from middle- and upper-class families, the adoption studies that might settle this issue are extremely improbable. Consequently, we must be content with the strong likelihood that there is an as yet unknown genetic vulnerability to anorexia nervosa, stress, and/or depression that interacts in some as yet unspecified way with culture, family, personality, and life circumstances to produce anorexia nervosa.

### Pregnancy and Birth Complications

Approximately 20 percent of the anorexics studied in several investigations were born to mothers who experienced complications during pregnancy (e.g., infection) or delivery (e.g., prolonged labor) (11). This is a higher rate of perinatal problems than is associated with the births of normal and neurotic females (11). The specific effects of such early trauma are unknown. They could subtly affect the basic mechanisms in the brain for controlling hunger, or they might compromise the development of higher-order brain centers that later play a role in cognitive development and coping with stress.

## Predisposition: The Individual Within the Family

### A Note of Caution

Many researchers and clinicians have attempted to specify the familial characteristics that increase the risk of anorexia nervosa (11, 34). Classic books, such as Bruch's *The Golden Cage* (5) and Levenkron's *The Best Little Girl in the World* (21), have done much to increase our understanding of familial risk factors. Unfortunately, their astute clinical observations have been transformed into a stereo-

type of overcontrolling mothers and perfectionist but emotionally distant fathers (34). This oversimplification, like all conveniences, is tempting, but subject to breakdown with repeated use. It should be resisted because very few concrete facts about familial risk factors have been established (34). This is attributable to the tremendous variability in cases of anorexia nervosa, the inherent limitations of verbal reports gathered after the onset of a serious illness, and the paucity of studies that compare the families of anorexics to the families of patients having either no disorders or another equally serious psychiatric problem (11, 34). Unless otherwise noted, the "findings" and "facts" reviewed in the following sections should be considered strong possibilities deserving of further research.

## Family Characteristics

The study of demographic characteristics associated with an increased risk of anorexia nervosa has produced more negative than positive results. Anorexia nervosa seems to be unrelated to religious affiliation, family size, proportion of females to males in the family, birth order, and family dissolution due to separation, divorce, or death (11). Across studies only two consistent findings emerge. The families tend to be socially advantaged (see Chapter 6), and the parents tend to be somewhat older than average (11).

## Familial Attitudes and Values

Sociocultural factors play a role in the development of eating disorders (see Chapter 7), but it is not known exactly how misinformation and dangerous values are directly conveyed to children. Based on case histories of anorexics and on investigations of achievement motivation, it is reasonable to *hypothesize* that (1) the family is the principal interpreter and transmitter of cultural values, and (2) some families place their children at risk for eating

disorders by overemphasizing slenderness, calorie-consciousness, youthfulness, perfectionism, reliance on external sources of self-esteem, or any number of other factors that have been implicated in anorexia nervosa (11).

This theory is intuitively appealing, but the existing evidence is either inconsistent, anecdotal, or based on studies that lack the appropriate comparison groups (11). Approximately 25 percent of the families of anorexics are abnormally preoccupied with food, physical fitness, and physical appearance, as evidenced by chronic dieting, problems with weight fluctuations, adherence to unusual food regimens, and professional involvement in the food, nutrition, or health industry (11). Consistent with the theory of familial transmission, *some* studies describe a tendency in the fathers of anorexic girls to be ambitious and perfectionist with respect to appearance and performance, but lacking in self-confidence and nurturance (11).

These findings raise the possibility that in *some* families parents inadvertently set the stage for anorexia nervosa by encouraging their daughters to define themselves in terms of slenderness, rigid self-control, and the potentially contradictory characteristics of individualistic ambition versus a need to please others (see Chapter 7). In effect, some parents unwittingly promote anorexic values and behaviors instead of a broad self-concept and a high level of self-acceptance.

It should be noted that several carefully designed studies (for example, Garfinkel and others [13]) have revealed very few differences between the parents of anorexics and the parents of normal young women matched for age and socioeconomic status. This has two very important implications for an understanding and application of a multidimensional perspective concerning the causes of anorexia nervosa. First, this eating disorder can develop in the absence of blatantly distorted family values. Second, anorexia nervosa may not arise even in the presence of such values (11, 13).

## Parent-Child Relationships

The various theories and investigations of family attitudes presume that faulty parenting distorts the child's relationship to her body, to other people, and ultimately to her self—her own needs, goals, and abilities, as well as *her* capacity for evaluating what is best for her (4, 6, 21, 22; see Garfinkel and Garner [11] for a review). What follows is my distillation of some basic *hypotheses* about the role of distorted parent-child relationships in the development of anorexia nervosa.

Anorexia nervosa begins with the relationship between a constitutionally vulnerable child and parents who are unable to provide the emotional support and directive guidance that children need. These parents are often intrusive, overcontrolling, and unconsciously dependent on the child for gratification. This parenting style prevents the child from learning to identify her own needs and emotions, thereby discouraging her from forming a personal identity within the family. Instead, she develops an abnormal attachment to the parents, usually the mother. The cement of this unhealthy bond is a set of powerful but poorly articulated emotions—fear of abandonment, anger, contempt, and guilt. Ultimately, this distorted relationship creates in the child a fundamental mistrust of self and others and a deep sense of helplessness in the interpersonal realm.

During childhood, insecurity is masked by excessive compliance with parental demands and by compulsive overachievement in sports and in school. Although these compensatory measures serve the child and her parents well in the prepubertal years, they wed both parties to the role of "good child." This leaves the daughter unprepared to disengage and differentiate herself in response to the physical changes (such as puberty) and interpersonal demands of adolescence (such as beginning high school or taking risks). Because the resulting helplessness and resentment threaten the very foundations of her existence, she submerges them in

hyperactivity, perfectionism, and culturally sanctioned dieting. Unprepared to be herself and unwilling to remain her parents' child, the anorexic tries to maintain a sense of control by ruling her body and bending others to the tyranny of her weight loss efforts. "Though anorexic patients may die from their condition, it is not death they are after but the urgent need to be in control of their own lives" (4, p. 269).

Thus, hunger and food become the focus of an ambivalent battle for identity and autonomy. Later they become the battleground for a self-defeating mixture of desperate motives and intense emotions. Eating (gorging) produces an infantile sense of security, but it also generates fear, guilt, and self-contempt over lack of control. Food refusal represents control, independence, and defiance, but it is a lonely, joyless, and exhausting pursuit that only leaves her facing the twin demons of anorexics—ravenous hunger and loss of control. The struggle with these powerful demons is heated and lonely. Her parents, who "gave her everything," are shocked when their "little girl, the one that never gave us any trouble," becomes isolated, angry, and defiant.

According to this perspective, adolescence traps the anorexic-to-be between cultural pressures for individuation, the marked ambiguities of the female role in modern society (see Chapter 7), parental pressures for continued dependency, and her own deep-rooted insecurities. She attempts to escape by renouncing involvement in the abstract and complex issues of adolescent development, and turning instead to a concrete and presumably controllable feature of self—weight. Under the burden of the irreconcilable forces and of physical hunger, three latent consequences of her lack of differentiation from parents emerge as cardinal features of anorexia nervosa: (1) severe body image disturbance; (2) an inability to interpret accurately or trust hunger and other internal sensations (anger, sexuality, fatigue); and (3) "an all-pervasive sense of ineffectiveness" (6, p. 9).

Within this tangle of inadequacies, motives, and anxieties reside the tragic paradoxes of anorexia nervosa. Struggling to salvage an existence that is poorly differentiated from others, the anorexic seeks to be "special" by embracing a set of externally determined values that submerge her true self in a sea of hunger, obsessions, and helplessness. Struggling to be attractive (slender) and socially acceptable, she is initially praised and admired by friends and relatives who envy her dedication and self-control. But as dedication becomes obsession, she becomes repulsive, isolated, and inaccessible (18, 20).

The descriptions of distorted parent-child interactions offered by Bruch (4, 5), Levenkron (21, 22), and others are extremely valuable. They enable us to empathize with both the psychological experience of anorexics and their parents' bewilderment over the emergence of psychopathology in someone who had previously been "the best little girl in the world" (21). They also direct therapists to the developmental issues that terrorize anorexics and make them so resistant to weight restoration. It must be kept in mind, however, that such distorted parent-child interactions are found in only a third to a half of all cases of anorexia nervosa (34). They have also been reported in association with other psychological disorders and in families with no discernible psychological disorder (11).

## Family Systems Theory

Theories about distorted parent-child relationships assume that negative influences emanating from the parents are filtered through vulnerable children to produce an adolescent with anorexia nervosa. According to this perspective, the parents are the cause and an anorexic adolescent is the effect. Family systems theorists reject this undirectional approach in favor of a transactional model in which "the patient's symptoms can be thought of as being evoked, supported, and reinforced by certain transactions in the system, and to play a part in the

family's entire psychological economy" (34, p. 52). If the family is understood as a system, then psychopathology is not solely a characteristic of the anorexic, because each member of the family, including the anorexic, contributes to, and is affected by, the eating disorder (11). Somehow, anorexia nervosa enables the anorexic *and* various members of the family to fulfill a number of implicit or explicit goals, all of which place the stability of the family above the integrity of the individual (20).

Dr. Selvini Palazzoli of Italy and Dr. Salvatore Minuchin of the United States have identified the following systemic themes as the familial context for anorexia nervosa (11, 33):

1. *Avoidance of Conflict*: Within these families there is little opportunity for, or leadership in, the resolution of natural conflicts. Communications are coherent, but there is a rigid insistence on the maintenance of tranquility via limitations on permissible topics for discussion, adherence to a belief in complete parental authority, and overconcern with external appearances.

2. *Pseudomutuality*: Although all family members are frequently angered or discouraged by unresolved conflict, overt expressions of emotional and intellectual dissatisfaction are not permitted. Rather, an uneasy spirit of self-sacrifice and a facade of harmony prevail. Within such an atmosphere direct communication of individual feelings or overt protests of unfairness are seen as selfish acts of betrayal.

3. *Enmeshment*: The children, parents, and/or grandparents tend to be so wrapped up in each other's lives that there is little privacy or little encouragement to have individual opinions, interests, and aptitudes. Family members are quick to answer for each other and otherwise intrude on the individual's thoughts and feelings. This enmeshment blurs the distinction between individuals and retards the development of individuality and autonomy.

4. *Triangulation*: Given their strong connections to their families of origin and their lack of opportunity for individual expression, the parents of enmeshed families tend to be frustrated and resentful. Divorce appears to be relatively rare *in the families studied*, but marital dissatisfaction is common. Since the parents cannot express their feelings openly or resolve their problems directly, they use emotional blackmail to enlist the anorexic-to-be as an ally against the other parent or as a scapegoat for family

problems. Constrained by pseudomutuality and by the family's rigid avoidance of conflict, the anorexic is unable to explore and work through the inconsistency between such manipulativeness and the aforementioned overprotectiveness. The resulting confusion, anger, and despair further erode the process of healthy identity formation.

The insistence of systems theorists that anorexia nervosa originates and is sustained within the context of family values and transactions has been a major contribution to the treatment of this disorder (29). Family systems theories also provide a broader framework for understanding the developmental deficits described by Bruch and others. Moreover, the notion that the disorder sustains the family in some way helps explain two aspects of treatment that educators may find puzzling. First, some families are extraordinarily resistant to acknowledging their child's problem and arranging therapy for either the child or the family (20). Second, in some cases, as the anorexic begins to show great improvement in eating habits and psychological status, the parents begin to have increasing marital difficulties and personal problems (8).

Although this warning may be proving tiresome, it must be noted that great caution is necessary in interpreting and applying family systems theory (31, 34). Not all families of anorexics have these characteristics, nor are these characteristics specific to the families of patients with eating disorders. Moreover, family systems theory is derived from the observation of intact families, and a significant number of anorexics come from homes that were "broken" by divorce or death well before the onset of anorexia nervosa (34).

## Individual Psychological Predispositions

The following four factors have been the subject of considerable discussion in the recent literature on anorexia nervosa. They are reported with sufficient regularity to suggest that they may be

risk factors, but the possibility remains that all but the first are manifestations of anorexia nervosa, not causes of it (12).

## Weight Problems

Some experts have found that many of the anorexics they treated were overweight as children or immediately before the onset of their eating disorder (2, 12). Other researchers have either failed to confirm this finding or have found that the association between prior weight control problems and anorexia nervosa holds only for bulimic anorexics (11, 12). Where it is present, childhood obesity may increase the risk of adolescent anorexia nervosa by stimulating a premature puberty and by sensitizing the child to both the importance of external appearance and the cruelty with which most people react to obesity (8, 12).

## The Best Little Girl in the World

Many anorexic adolescents are described as having been socially anxious children who coped with their insecurities by becoming *overly* sensitive and compliant to the wishes of others (2, 5, 12, 22). They developed, and were reinforced for, high standards for academic and athletic achievement, but such perfectionism represented a strong need to obtain the approval of others, rather than a solid sense of their own inner needs and values. As noted previously, this external orientation makes it difficult to individuate during adolescence and easy to absorb the sociocultural pressures for slimness and fanatical self-control.

It seems likely that growing up as an overcontrolled, compliant child would increase the risk of restricting, as opposed to bulimic, anorexia nervosa. The contrast between the image of the "best little girl in the world" and the stormy mood swings and multiple impulse control problems of the bulimic anorexic suggests that the dynamics of this subtype may well be different (see Chapter 9).

## Perceptual Distortions

As discussed in Chapter 2, many anorexics are unable to perceive and correctly interpret internal states such as hunger, satiety, anger, or fatigue (4, 6, 11). Although interoceptive disturbances are found in other psychological disorders, they are probably fundamental to the psychopathology of anorexia nervosa (4, 11). Alienation from inner messages about hunger, fatigue, anger, and pleasure produces a profound mistrust of the body and therefore the self. Such deficits would certainly promote the external orientation that marks the "good little girl"; divorced from internal guidance, she must turn to others for the definition and verification of her motives and interests.

This dependency only intensifies the anorexic's insecurity, for the conviction that others know what is going on inside her better than she does produces a powerful sense of vulnerability to being controlled and exploited. Eventually mistrust of self and others becomes the basis for the "all-pervasive sense of ineffectiveness" (6, p. 9; 11; 22). The antidote to helplessness is often "severe discipline" of the body, schoolwork, time, and relationships—the perfectionism noted in the previous section (6, 11). If we add mistrust of self and others, perfectionist regimentation, excessive sensitivity to the opinions of others, and a cultural obsession with thinness, the resulting sum approaches anorexia nervosa.

There is some evidence that interoceptive disturbances, mistrust, and a fundamental sense of personal ineffectiveness are positively correlated with the anorexic's classic tendency to overestimate her own body size. At present, however, nothing conclusive can be said about the strength and theoretical significance of the association (11). All these factors may be the product of an intrusive parenting style (enmeshment) that prohibits the child from learning to identify and label internal states correctly and from experiencing her body as her own

(4, 11). Or it may be that low self-esteem and other forms of self-rejection, which could develop in adolescence or childhood, produce an unwillingness to "listen" to herself and a tendency to misperceive her size in a manner that reflects negatively on the self (11). Still another possibility derives from the observation that, as "normal" girls age through adolescence, their estimation of body size and their acceptance of secondary sexual characteristics become increasingly realistic. This suggests that perceptual disturbances may somehow be linked with the anorexic's cognitive immaturity, as discussed in the next section (11).

## Distorted Thinking

Most people—teachers, parents, friends, even therapists—are mystified by the anorexic's unwillingness to change despite the obvious negative consequences of prolonged starvation. David Garner and his colleagues believe that, although anorexia nervosa arises out of an external orientation, the established eating disorder is regulated more by a set of personal rules, beliefs, and attitudes than by social or physical outcomes (11, 14, 15).

According to Garner, the anorexic's self-starvation is logical to her, no matter how irrational it seems to others. Self-starvation follows directly from a set of assumptions, beliefs, and values that we recognize as distorted, but that she has assimilated into her characteristic manner of thinking about herself, the world, and the future. At the center of these distorted principles is the culturally sanctioned conviction that thinness is absolutely essential (11, 14, 15). Revolving around this belief is a constellation of interrelated assumptions and "deductions," all of which lead to the avoidance of proper nutrition and the *self*-reinforcement of weight *loss* (11). Here are some of the principles that

underlie anorexia nervosa:

1. One should strive for perfection; asceticism is superior to indulgence.
2. Slenderness and losing weight are good because they are the epitome of asceticism. Weight gain is indulgent and therefore disgusting. It means becoming fat.
3. Weight and shape are the sole or most important criteria for determining personal worth.
4. Complete self-control is necessary for me to be good; weight gain means that I am out of control and therefore bad.
5. Complete self-control necessitates complete certainty in making decisions about right and wrong, in social interactions, and in behavior.
6. A mature body involves weight gain and some loss of control; therefore I cannot cope with an adult shape.

Assumptions like these are dysfunctional in terms of their simplicity, concreteness, rigidity, and dichotomous nature, but they are not incomprehensible. In light of the sociocultural and familial factors discussed thus far, it is easy to see how an adolescent girl (or boy) might come to worship thinness as a tangible god.

These deep-seated and often unconscious principles are translated into anorexic thoughts, motives, and behaviors by a set of logical errors. As noted previously, "logical errors" is a relative phrase here. From our perspective much of the anorexic's thinking is illogical. For the anorexic, however, the thoughts ("I am losing control") and feelings (panic) produced by these "errors" are immediate and convincing, given the distorted assumptions at their base. This logic of immediacy makes the subsequent behavior (no more dinners) seem not only very sensible, but essential.

# Precipitants

## Puberty

British psychiatrist A. H. Crisp, author of the well-known book, *Anorexia Nervosa: Let Me Be* (8), maintains that puberty and its developmental challenges are the major factors in the conversion of predispositions (vulnerabilities) into anorexia nervosa.

Crisp's emphasis on puberty is related to his theory that the anorexic is intensely afraid of biological and psychological maturity, both of which are directly connected to pubertal weight gain. According to Crisp, this anxiety motivates a defensive regression to physical and psychosocial immaturity to the extent that continuing weight loss is experienced as the sole insurance against engulfment by the realities of adolescence. The outcome of this flight to save the self is the loss of self in hunger and anorexia nervosa.

According to Crisp, the rejection of maturity and the slide into anorexia nervosa begin with dieting in the form of carbohydrate avoidance. The conscious motivation for reducing is generally very similar to that for other adolescent dieters—the wish to be more attractive, identification with a parent who is dieting, the fact that friends are dieting. In the anorexic-to-be, however, dieting becomes the vehicle for coping with the personal, social, and sexual significance of the body fat that appears in increasing amounts during the normal processes of physical maturation in females. Most people equate puberty in girls with menstruation. Actually, menstruation occurs late in puberty because it is the culmination of a growth spurt characterized by a predictable sequence of events: breast development, the appearance of pubic hair, enlargement of the hips, and then deposition of fat on the buttocks, thighs, lower abdomen, and upper arms.

A number of factors may combine with prejudice against obesity to render the anorexic-

to-be hypersensitive to the normal fattening of the feminine body in adolescence. As noted previously, childhood obesity or weight control problems can establish a personal association between fat and shame. In addition, girls who begin their pubertal growth spurt at a younger age than peers are often the focus of negative attention from family and female friends, and they tend to have a more negative body image and lower self-esteem than girls who do not develop early (30). In this regard there is some evidence suggesting that on the average anorexics are "early maturers" (8).

Social reactions to the bodily transformations of puberty are but one source of the anxiety that may initiate anorexia nervosa (8, 30). There are also personal sources pertaining to loss of control and to sexuality. Based on ignorance of the body's function and on negative childhood experiences related to sexuality (for example, being the victim of child sexual abuse), the pubertal girl may experience the growth and fattening of her body as an unexpected, uncontrollable, and therefore frightening imposition. This sense of helplessness may be compounded by a burgeoning realization of the sexual significance of the mature female shape, and by a dysfunctional family system that shares and thus reinforces the girl's anxiety and confusion.

Crisp emphasizes that the anorexic has a phobic fear of body fat, not of eating or food per se. But the real fear is of what pubertal body fat represents, and unceasing safeguards against it constitute the only way she knows to manage a myriad of interlocking forces—sociocultural pressures for slenderness and preoccupation with body shape, profound disturbances within the family, lack of self-esteem, and helplessness in the face of internal changes and external demands related to the passage into adult femininity. In effect, the anorexic condenses the challenges of identity formation in adolescence into the following equation: To control femininity is to control her body is to reduce fat is to reduce eating. In this regard Crisp's theory echoes Bruch's:

"The key seems to be the sense of *control* and *confidence* that comes with restrained eating (8, p. 65; italics in the original).

The attempt to maintain a weight well below that which supports biological and psychological femininity (or masculinity) produces the savage paradox that underlies all eating disorders: restrictive dieting ultimately results in a loss of control over eating. As discussed in Chapter 2, dieting produces an ever-present hunger and a realistic danger of eating voraciously following relaxation of control. Some anorexics try to solve this dilemma by bingeing and then purging, but the result is often tragic—the fear of food is strengthened, the association of purging and eating is strengthened, and the body and mind are weakened. Terrified of food and weight gain, the anorexic is doomed by hunger to think about it, forage for it, dream of it, read about it, prepare it for others, do everything but eat it or retain it (17, 19).

## Other Precipitating Events

The range of ages at which anorexia nervosa begins (see Chapter 6) makes it clear that its onset does not always coincide with a specific developmental crisis such as puberty. Anorexia nervosa is also triggered by external challenges that, like puberty, may overwhelm the adaptive resources of teenagers who are unprepared for autonomy, abstract thinking, sexuality, and other developmental tasks of adolescence (5, 12, 14).

Although researchers and confused family members are often unable to detect specific precipitants, three general conclusions about them are warranted (12). First, the triggers for anorexia nervosa are varied. Second, the events that unleash this eating disorder are qualitatively similar to those that initiate different psychological disorders for some people and only temporary distress for others. Third, and most important, no matter how tragic or innocuous the precipitating life events appear to

others, the circumstances are significant to the anorexic-to-be because, in various combinations, they threaten her self-control and self-worth, they overwhelm her ability to cope with change, or they enhance the perception that weight loss is a solution to all her serious problems (12).

It is useful to divide the immediate precipitants of anorexia nervosa into three categories (after Garfinkel and Garner [11, 12]; [14]).

### *Separations and Losses*

This category encompasses actual physical separations as well as significant reductions in the stability of the family or school environment. Thus, anorexia nervosa has been precipitated by the death of a parent or sibling, divorce, parental infidelity, an intensification of family arguments or violence, serious physical or mental illness in a family member, moving to a new school district, and going off to college.

### *New Demands and Expectations*

Other circumstances can also precipitate anorexia nervosa by making the vulnerable individual feel incompetent and lost in the face of an increased number of demands, many of which are ambiguous. These situations include a first heterosexual relationship, getting mediocre grades on the initial round of high school or college exams, trying to qualify for an athletic team or dance program, or a notable accomplishment by a sibling. Some "abnormal" stressors also deserve mention, notably sexual imposition by family members or friends (31). It must be emphasized that failure and loss of control need not be actually experienced. Uncertainties about effectiveness and control may be intolerable enough to motivate the anorexic-to-be to begin dieting as a means of self-fortification.

*Weight Loss as a Solution to Problems*

Anorexia nervosa may be precipitated by events that merge with sociocultural factors in suggesting that the person should pay more attention to her body and start losing weight (5, 11). Some anorexics begin their relentless dieting in response to criticism and teasing (either friendly or malicious) received after a mild weight gain. In some cases parents, teachers, or coaches directly encourage adolescents to reduce so that they may qualify for, and compete more successfully in, certain extracurricular activities (such as sports or dance) or employment (9). A few girls become anorexic after a physical illness in which there is actual loss of appetite (true anorexia) and weight. The pleasure they experience and the compliments they receive are enough to forge their lack of self-esteem and the sociocultural equation of slenderness and desirability into a resolution to get skinnier.

## Perpetuators

### Starvation

The effects of starvation, as described in Chapter 2, play a very significant role in the entrenchment of anorexia nervosa (11, 17). The anorexic must control her hunger as part of her efforts to reduce, but this enterprise is doomed by the biology of self-preservation. Starvation produces chronic hunger, an obsession with food, emotional instability, and self-absorption, all of which intensify the anorexic's defenses against eating and alienate her from other people. Struggling to control hunger, the anorexic creates an exaggerated and perpetual need for food.

Most anorexics feel the urge to binge-eat, and some do when restraints fail or are loosened by well-intentioned but ineffective treatment. Binge-eating consolidates anorexic attitudes and behaviors by verifying the anorexic's "distorted"

fear that going off her diet means a complete loss of control. Moreover, relative to the proportion of fat versus muscle lost during dieting, the weight gained during refeeding consists of more fat than muscle, and this fat tends to be deposited in "sensitive" regions such as the stomach and buttocks.

Starvation also increases irritability and depression, an effect that is often unintentionally magnified by the use of caffeine-containing diet aids such as over-the-counter appetite suppressants, coffee, tea, and low-calorie colas. Frequently accompanying this emotional deterioration are a variety of physical aberrations, including stomach upset, dizziness, headaches, intolerance of cold temperature, and abnormal sensory experiences. Together, emotional instability and physical weakness undermine self-control, chip away at the anorexic's shaky self-esteem, and further widen the rift between self and others.

## Gastrointestinal Changes

Anorexics frequently complain of feeling bloated, stuffed, or distended even after a small meal (11, 12). As they are highly sensitive to "feeling fat" in any manner, these experiences discourage their return to normal eating. "Bloating" is due in part to the fundamental disturbances in interoception, but it probably also reflects an increase in the time required for the stomach to empty its contents into the intestines, as well as the chronic constipation experienced by many anorexics. Ironically, constipation is a particular problem for those who abuse laxatives in the fallacious belief that they promote weight loss.

## Vomiting

Whether or not they binge, anorexics may use self-induced vomiting as a weight-control device. Self-induced vomiting is psychologically dangerous because it is so reinforcing that the potential

for dependency is high (19). Vomiting provides relief from anxiety, anger, and guilt; it produces a sense of ascetic emptiness and purity; and it constitutes a deceptively simple and initially effective solution to the challenge of losing weight while controlling hunger (7, 19, 23). Since failure to vomit after eating may be experienced as a frightening loss of control over the body, vomiting is negatively reinforced by an immediate reduction in the fear of weight gain. In other words, anorexia nervosa may be sustained by the benefits of vomiting and the cost of not doing so.

## Hypothalamic Dysfunction

The hypothalamus is a relatively tiny but extremely influential collection of neural cells located near the pituitary gland at the base of the forebrain. This "structure" has attracted the attention of physicians and psychologists interested in anorexia nervosa because damage to the hypothalamus may disrupt the normal homeostatic mechanisms that control both hunger and menstruation (3).

No one has been able to demonstrate that anorexia nervosa in humans is the result of damage to the hypothalamus. There is substantial indirect evidence, however, that this important brain area is functioning abnormally in anorexics. It is very difficult to separate cause and effect here, but the evidence seems to favor the theory that hypothalamic dysfunction is probably a result of weight loss, caloric restriction, chronically high levels of emotional distress, and self-induced vomiting (11, 18, 33).

## Disturbances in Body Perception and Cognition

Disturbances in body perception and irrational beliefs about eating are perpetuators of anorexia nervosa, as well as risk factors. A person who is very much afraid of weight gain, and who sees or feels herself as fat will be highly motivated to continue starving herself, no matter what the scale

or the doctor or some chart of "normal" weights says. The compliments and other positive experiences produced by the initial phase of dieting verify the anorexic's dichotomous reasoning that good = success = thinness = weight loss = dieting = not eating versus bad = failure = "fat" = weight gain = not dieting = normal eating or bingeing (19). This personal validation of culturally based beliefs significantly increases the probability of making the logical errors (such as overgeneralization) that isolate the anorexic from the corrective input of others and substantiate the need to pursue thinness and avoid weight gain at all costs (11).

## Secondary Gain

In psychiatry "secondary gain" refers to the benefits of a psychiatric illness beyond its ability to protect the individual against the experience and expression of intolerable conflict (the primary gain). The secondary gains in anorexia nervosa are the attention received, the sense of control over the family or therapist, and the drama created by a much publicized disorder with life-or-death consequences (11).

## Precipitants Created by Anorexia Nervosa

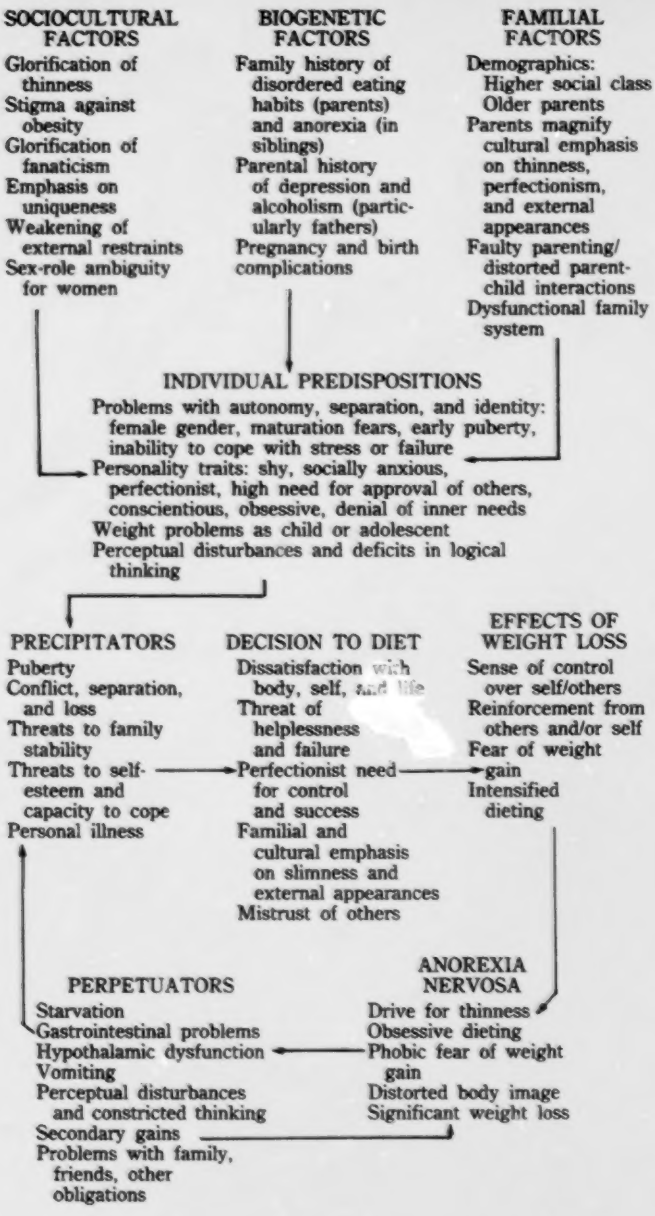
In its initial stages the effects of anorexia nervosa are usually quite positive for the individual (15). As discussed in Chapter 2, however, over time the disorder wreaks havoc in the physical, social, and psychological realms (23). Self-starvation weakens the energy reserves of a person who needs all her strength to combat her own biology. Self-starvation also generates considerable conflict within a family that is often particularly ill-suited for the effective detection, identification, and solution of emotional disturbance. Students who are having

trouble at home usually turn to others for support, but the anorexic's hostile refusal to eat despite obvious negative consequences leads to rejection by friends, teachers, and even physicians and psychologists. Besides, the anorexic sees these people as threats because she correctly perceives that they are indeed conspiring to get her to eat. Thus, the anorexic is left alone with her overriding need to be in control, and she becomes increasingly inefficient, miserable, alienated, and disturbing.

These negative effects do not convince the anorexic that she should abandon her excessive dieting. Instead, they strengthen the need to diet by increasing the probability of precipitators (such as separation, threats to self-esteem) and by decreasing the ability of the anorexic to draw upon other resources for coping.

## A Multidimensional Model

Figure 8–1 illustrates the interplay of predisposing, precipitating, and perpetuating factors in the development and maintenance of anorexia nervosa. Together these forces constitute a web that imprisons the anorexic in a tangle of sticky paradoxes (23). Fiercely determined to be a unique person, she dissolves into an impersonal disorder with predictable features. Desiring popularity and acceptance, she ends up alienated from all but the most understanding people. Seeking domination over hunger, she becomes a slave to it. Hoping to control her body and her life, she winds up in a hospital with tubes in her arm and a schedule of activities entirely determined by others. Dissatisfied with traditional femininity, she comes to embody (literally) its most exaggerated characteristics: passivity, helplessness, hyperemotionality, and powerlessness. Trying to break free, the anorexic wields the only weapon she can understand—her control over her body weight and shape—and thus the web is renewed with each attempt to sever it.


SOCIOCULTURAL FACTORS
Glorification of thinness
Stigma against obesity
Glorification of fanaticism
Emphasis on uniqueness
Weakening of external restraints
Sex-role ambiguity for women
BIOGENETIC FACTORS
Family history of disordered eating habits (parents) and anorexia (in siblings)
Parental history of depression and alcoholism (particularly fathers)
Pregnancy and birth complications
FAMILIAL FACTORS
Demographics: Higher social class Older parents
Parents magnify cultural emphasis on thinness, perfectionism, and external appearances
Faulty parenting/ distorted parent-child interactions
Dysfunctional family system
INDIVIDUAL PREDISPOSITIONS
Problems with autonomy, separation, and identity: female gender, maturation fears, early puberty, inability to cope with stress or failure
Personality traits: shy, socially anxious, perfectionist, high need for approval of others, conscientious, obsessive, denial of inner needs
Weight problems as child or adolescent
Perceptual disturbances and deficits in logical thinking
PRECIPITATORS
Puberty
Conflict, separation, and loss
Threats to family stability
Threats to self-esteem and capacity to cope
Personal illness
DECISION TO DIET
Dissatisfaction with body, self, and life
Threat of helplessness and failure
Perfectionist need for control and success
Familial and cultural emphasis on slimness and external appearances
Mistrust of others
EFFECTS OF WEIGHT LOSS
Sense of control over self/others
Reinforcement from others and/or self
Fear of weight gain
Intensified dieting
ANOREXIA NERVOSA
Drive for thinness
Obsessive dieting
Phobic fear of weight gain
Distorted body image
Significant weight loss
PERPETUATORS
Starvation
Gastrointestinal problems
Hypothalamic dysfunction
Vomiting
Perceptual disturbances and constricted thinking
Secondary gains
Problems with family, friends, other obligations

## Figure 8–1. A Multidimensional Model of Anorexia Nervosa

*Sources:* Garfinkel and Garner (11), Garner and Garfinkel (16), Johnson and Maddi (19), Slade, cited in Vandereycken and Meermann (32).

# Conclusions and Implications

## A Multidimensional Perspective

*Conclusion.* Although anorexia nervosa is often referred to as a psychiatric "illness," it is not caused by demonstrable damage or disease in the brain. Moreover, there is no single "cause" of anorexia nervosa that is necessary or sufficient for this eating disorder to develop. This frustrating fact, in combination with the variability of symptom intensity and configuration, necessitates the adoption of a multidimensional perspective. According to this model, anorexia nervosa is the outcome of an interaction among three distinct types of influences: predispositions, precipitants, and perpetuators. The predispositions make the person vulnerable to this eating disorder, the precipitants trigger the onset of anorexia nervosa, and the perpetuators interact with the predisposition and the characteristics of the disorder to sustain the problem.

*Implications.* On the positive side, multidimensionality means that there are many interesting topics that can be profitably discussed within a variety of different classes or lessons (see Table 8–1). On the negative side, the necessity of a multidimensional perspective makes it very difficult to answer the students' concrete and legitimate question: "But what *causes* anorexia nervosa?" If teachers select one of the risk factors, perceptive students will quickly verify the model by noting instances in which the risk factors are present and the disorder is absent, or situations in which the risk factors are absent and the disorder is present. Even if students uncritically accept a statement about personality or family dynamics, there is the danger that the multidimensional perspective will be translated into a one-dimensional and misleading conclusion about who is at fault, either the person or the family.

## Table 8–1. Discussion Topics Pertaining to Eating Disorders

| Topics | Courses |
|---|---|
| **PREDISPOSITIONS** | |
| Sociocultural Factors | History, English Literature[a] Speech & Communications, Home Economics, Health & Science, Psychology |
| Biogenetic Factors | Biology, Health & Science, Psychology |
| Familial Factors | History,[b] Health & Science, Home Economics, Psychology |
| Individual Factors:<br>Psychological preparation for adolescence<br>Personality and the need for approval<br>Weight problems as a child<br>Self-perception, stress, coping, and problem solving | Health & Science, Psychology |
| **PRECIPITANTS AND PERPETUATORS** | |
| Puberty | Biology, Sex Education, Health & Science, Psychology, Home Economics, History |
| Conflicts, stress, and problem solving<br>The self, self-control, and self-esteem | Health & Science, Psychology, English Literature, Drama, Art[c] |
| Dieting, hunger, and natural weight regulation | Biology, Health & Science, Home Economics, Psychology |
| **PERPETUATORS** | |
| Starvation<br>Biological disturbances<br>Distorted perceptions & thoughts<br>Interpersonal problems | Biology, Health & Science, Home Economics, Psychology |

*Note:* It is assumed that the major signs and symptoms will be a part of the presentation, regardless of the class in which anorexia nervosa is discussed. Consideration of diagnostic issues (such as anorexia nervosa versus a major depressive disorder) is appropriate for health and science, psychology, and biology.

[a]See Appendix II for a list of fictional and nonfictional books on anorexia nervosa that might be appropriate for high school English courses.

[b]The relationship between eating disorders and social class, the changing nature of roles within the family, and changes in concepts of masculinity and femininity make anorexia nervosa an interesting topic for history or social studies.

[c]Drama and art are excellent ways of exploring the interplay among self-concept, relationships, problem solving, and self-acceptance.

I have found no simple solution to the challenge of providing students with correct information about the multidimensional basis of anorexia nervosa or bulimia (see Levine [23]). All I can honestly say is that teachers should "remain skeptical about facile formulas that purport to explain anorexia" (34, p. 44). They should be prepared to explain the concepts of predispositions (vulnerability), precipitants (stressors), and coping, and to illustrate them with an experience that most students can relate to, such as test anxiety. Finally, in reply to some variation of "Who's fault is it?" I suggest the following: "Each case of anorexia nervosa is different and each is the result of a number of forces within the person, the family and our culture. What's really important is that the person, the family, and friends work together to get help for the eating disorder and to increase their ability to care for each other."

## Predispositions and Precipitants

*Conclusion.* The multidimensional model states that predispositions interact with precipitants to shape the selection of dieting as a solution to the problem of life as a teenager or young adult. In general, the predispositions are sociocultural, familial, and individual factors that increase the risk that the vulnerable individual (a) will have difficulty meeting the myriad challenges of adolescence and (b) will choose the fanatical management of weight and shape as a means of coping with threats to self-esteem, security, and/or autonomy. The precipitants are those normal or unusual circumstances that unleash the relentless pursuit of thinness by (a) significantly threatening the adaptive resources of the vulnerable individual and (b) suggesting that weight loss is a means of avoiding one's nightmares or realizing one's dreams.

*Implications.* Themes of vulnerability, stressors, and coping are difficult for teachers and students alike. The complexities of considering sex

roles, body image, and dieting have already been noted (see Chapters 6 and 7). In addition, the private and public self-consciousness of adolescents makes it difficult for them to discuss emotionally laden topics such as family interactions, personal inadequacies, puberty, rejection, and styles of coping, either constructive or destructive. Despite these obstacles, I strongly encourage teachers who are committed to a full examination of eating disorders to tackle these issues in a forthright but sensitive manner. Chapter 10 contains a number of specific suggestions for this enterprise. In addition, available curriculum guides for adolescent suicide, substance abuse, and domestic violence contain a number of helpful suggestions for teaching academic subjects that have a visceral component (see, for example, Levy [25]).

## The Family

*Conclusion*. Although many *theories* about the causes of anorexia nervosa clearly implicate the family, the available data from well-designed investigations simply do not permit a conclusive statement about the role of the family as a risk factor (34).

*Implications*. Teachers must be very cautious in explaining the theories described in this chapter and in applying them to individual cases that might come to their attention. For example, Bruch and others have characterized the mothers of anorexic girls as "over-controlling, intrusive, and domineering" (10, p. 15). Both research and clinical experience make it clear that these characteristics will not be present in all cases, or perhaps even in a majority of them (34). Even if they do seem to describe the parent of a particular student, the sensitive teacher should resist the urge to interpret this correlation as meaning that this parenting style caused the anorexia nervosa. Serious consideration must be given to the possibility that overconcern and intrusiveness are normal reactions when one's child is starving herself to death before one's eyes.

No matter how disturbed the family system, it is important to acknowledge that the support and participation of the family are crucial in the treatment and prevention of anorexia nervosa (24, 31). If possible, teachers should avoid blaming the family in their classroom presentations, their conversations with students, and their meetings with parents. This is easier to do by keeping in mind (a) that most parents of anorexics already feel guilty enough; (b) the distinct possibility that some of the features of enmeshed families may be *reactions* to the distress caused by a severely disturbed child; and (c) the emphasis of family systems theory on the role played by *all* family members, including the anorexic (18, 31, 34).

## Keeping the Multidimensional Perspective in Perspective

*Conclusion*. The sheer size and complexity of the multidimensional model of anorexia nervosa make it potentially overwhelming and therefore potentially useless for educators. Teachers need to be clear about its implications for their classroom and advising activities if this model is to be an effective part of the effort to prevent eating disorders.

*Implications*. Three things are necessary in order to keep the multidimensional perspective in perspective. First, teachers must realize that anorexia nervosa (as well as bulimia) is a puzzle for which we have many pieces, but no template for determining the pattern. Thus, the risk factors are important aspects of the picture, even though we do not as yet know how they fit together. Second, the variety of factors that contribute to anorexia nervosa point to the great impact that education could have on prevention. Teachers cannot be saviors, but their knowledge and their attitudes can certainly help overcome many of the predispositions, such as lack of self-acceptance, ignorance about the body, preju-

dice, pernicious values, and deficient coping skills. Third, since treatment is based on the understanding and unraveling of complex, multidimensional influences, it is clear that counseling anorexics is the province of well-trained experts. Teachers can serve as important sources of preventive education and referral, but no matter how well they understand the multidimensional perspective, they should never engage in ongoing counseling with these students.

## References


1. Beck, A. T., and Emery, G. *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books, 1985.
2. Bemis, K. M. "Current Approaches to the Etiology and Treatment of Anorexia Nervosa." *Psychological Bulletin* 85 (1978): 593–617.
3. Bennett, T. L. *Brain and Behavior*. Monterey, Calif.: Brooks/Cole, 1977.
4. Bruch, H. *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. New York: Basic Books, 1973.
5. _____. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978.
6. _____. "Four Decades of Eating Disorders." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 7–18. New York: Guilford Press, 1985.
7. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion*. New York: Doubleday, 1983.
8. Crisp, A. H. *Anorexia Nervosa: Let Me Be*. Orlando, Fla.: Grune and Stratton, 1980.
9. Dwyer, J. "Nutritional Aspects of Anorexia Nervosa and Bulimia." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S.W. Emmett, pp. 20–50. New York: Brunner/Mazel, 1985.
10. Eckert, E. D. "Characteristics of Anorexia Nervosa." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 3–28. Minneapolis: University of Minnesota Press, 1985.
11. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.




207

12. Garfinkel, P. E., and Garner, D. M. "The Multidetermined Nature of Anorexia Nervosa." In *Anorexia Nervosa: Recent Developments in Research*, edited by P. L. Darby and others, pp. 3–14. New York: A. R. Liss, 1983.

13. Garfinkel, P. E., and others. "A Comparison of Characteristics in the Families of Patients with Anorexia Nervosa and Normal Controls." *Psychological Medicine* 13 (1983): 821–28.

14. Garner, D. M., and Bemis, K. M. "A Cognitive-Behavioral Approach to Anorexia Nervosa." *Cognitive Therapy and Research* 6 (1982): 123–50.

15. Garner, D. M., and Bemis, K. M. "Cognitive Therapy for Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 107–46. New York: Guilford Press, 1985.

16. Garner, D. M., and Garfinkel, P. E. "Sociocultural Factors in the Development of Anorexia Nervosa." *Psychological Medicine* 10 (1980): 647–56.

17. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.

18. Hsu, L. K. G. "The Aetiology of Anorexia Nervosa" (editorial). *Psychological Medicine* 13 (1983): 231–37.

19. Johnson, C., and Maddi, K. L. "The Etiology of Bulimia: Bio-Psycho-Social Perspectives." *Annals of Adolescent Psychiatry* 13 (1986): 253–73.

20. Josephson, A. M. "Psychodynamics of Anorexia Nervosa and Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 78–101. Minneapolis: University of Minnesota Press, 1985.

21. Levenkron, S. *The Best Little Girl in the World*. Chicago: Contemporary Books, 1978.

22. _____. *Treating and Overcoming Anorexia Nervosa*. New York: Charles Scribner's Sons, 1982.

23. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

24. _____. "The Role of Culture in the Cause of Eating Disorders." *Kenyon College Alumni Magazine* 9 (Winter 1985): 8–13. Available from Michael Levine, Psychology

Department, Kenyon College, Gambier, OH 43022 (614–427–2244).

25. Levy, B. *Skills for Violence-Free Relationships: Curriculum for Young People Ages 13–18.* Santa Monica, Calif.: Southern California Coalition on Battered Women, 1984. Available from publisher, P.O. Box 5036, Santa Monica, CA 90405 (213–392–9874).

26. Orbach, S. "Visibility/Invisibility: Social Considerations in Anorexia Nervosa—A Feminist Perspective." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 127–38. New York: Brunner/Mazel, 1985.

27. Rosenhan, D. L., and Seligman, M. E. P. *Abnormal Psychology*. New York: W. W. Norton, 1984.

28. Sarason, I. G., and Sarason, B. R. *Abnormal Psychology: The Problem of Maladaptive Behavior*. 4th ed. Englewood Cliffs, N.J.: Prentice-Hall, 1984.

29. Sargent, J.; Liebman, R.; and Silver, M. "Family Therapy for Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 257–79. New York: Guilford Press, 1985.

30. Streigel-Moore, R. H.; Silberstein, L. R.; and Rodin, J. "Toward an Understanding of Risk Factors for Bulimia." *American Psychologist* 41 (1986): 246–63.

31. Tootell, C. "Working with Family Members in Support Groups and in Therapy." Workshop presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 8, 1985.

32. Vandereycken, W. and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.

33. Wooley, S. C., and Wooley, O. W. "Intensive Outpatient and Residential Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 391–430. New York: Guilford Press, 1985.

34. Yager, J. "Family Issues in the Pathogenesis of Anorexia Nervosa." *Psychosomatic Medicine* 44 (1982): 43–60.

CHAPTER 9

# The Causes of Bulimia: A Multidimensional Perspective

Determining the origins of bulimia is no easier than specifying the "causes" of anorexia nervosa. Combined with the variability of basic symptoms from case to case, the fact that there are bulimic anorexics, bulimics who were once anorexic, normal-weight bulimics, and overweight bulimics means that the "causes" of bulimia will be multiple, complex, and often controversial (7, 17). Like anorexia nervosa, then, bulimia is best understood through a multidimensional risk factor model that emphasizes the transactions between predispositions, precipitants, and perpetuators (16, 17).

Despite the heterogeneity of symptoms and causes, this chapter conceives of "bulimia" as a unitary disorder (12, 16). Recent research has demonstrated many parallels between normal-weight bulimia and bulimic anorexia, suggesting that the latter is more closely related to the former than to restricting anorexia nervosa (12, 16, 29).

## Biogenetic Predispositions

### Bulimia and Depression

Based on the following evidence, Pope and Hudson (26) maintain that bulimia is a variant of depression.

### *Symptom Similarity*

Many bulimic patients report some of the following symptoms of major depression in conjunction with their eating disorder: depressed mood; low tolerance for frustration; high levels of anxiety, guilt, tension, and irritability; low self-esteem; pessimism; problems in concentrating and thinking straight; lack of energy; sleep disturbances; and suicidal ideation (8, 17). In addition, the risk of serious depression or mania (the "major affective disorders") in bulimic individuals may be as high as 75 percent, as compared with a figure of roughly 15 to 20 percent for the general population (22, 26). This shocking statistic may overestimate the correlation between serious emotional disorder and bulimia, but it is clear that bulimia and affective disorder are linked. Moreover, in at least a third of the cases, depression or mania precedes the onset of bulimia, rather than follows it as a reaction to uncontrollable bingeing and purging (22, 26).

### *Family Histories*

Surveys of first-degree relatives (mother, father, brother, sister, son, daughter) reveal that the risk of major affective disorder in the immediate families of normal-weight bulimics is approximately 30 percent, while the risk of substance abuse is approximately 13 percent. These figures are very similar to the risk of affective disorder and substance abuse in the first-degree relatives of manic-depressive patients and bulimic anorexics (17).

### *Dexamethasone Suppression Test*

The dexamethasone suppression test is designed to investigate the body's response to the midnight administration of synthetic cortisol (dexamethasone) (6). Natural cortisol is a hormone released by the adrenal glands to help the body cope with stress. Even in the absence of specific stressors, during the morning and early afternoon the brain

periodically directs the adrenal glands to secrete cortisol as part of the body's circadian rhythms. In normal individuals midnight administration of dexamethasone activates a negative feedback mechanism whereby the brain detects the increased level of cortisol following ingestion and then suppresses its release on the following day. A significant number of severely depressed individuals show either no dexamethasone suppression or an early release from suppression (6). Thus it is interesting to find that a similar percentage of bulimic patients have the same abnormal responses (17, 26).

### *Drug Therapy*

Several well-designed studies have shown that, although antidepressant medication does not "cure" bulimia in most instances, it does significantly reduce both the frequency of bingeing and purging and the intensity of correlated depression in a large percentage of bulimics (14, 17, 18, 26).

### *Conclusion*

Collectively, these findings suggest a strong relationship between bulimia and affective disorder. The complexity of bulimia makes it unlikely that "bulimia is just an affective disorder," but the ongoing controversies over the linkage between bulimia and depression should not blind us to the fact that a family or personal history of depression definitely puts females at risk for bulimia.

## Familial Predispositions

### Style of Family Interactions

Investigations of the style and quality of family interactions have shown that the families of normal-weight bulimics are very much like the families of bulimic anorexics (see Johnson and Maddi [17] for a review). Relative to the families of restricting anorexics and normal controls, the families of

bulimics tend to have high levels of stress and conflict, poor problem-solving skills, a large amount of contradictory communication about autonomy and dependence, and low levels of interpersonal trust and emotional support. In addition, as predicted by the sociocultural perspective (see Chapter 7), there are often high expectations for individual achievement in the absence of clear support for personal autonomy, intellectual stimulation, and involvement in emotionally sustaining activities such as recreation and the arts.

This research *suggests* that the major concomitants of bulimia—low self-esteem, perfectionism, nonassertiveness, emotional instability, and impulsivity—are attributable in part to a chaotic and disengaged family that makes it very difficult for a constitutionally vulnerable child to recognize her own needs and feelings and to control them in accordance with high standards of behavior (5, 15, 17). Even though the data on family interactions make sense in light of symptom patterns, however, two observations highlight the extent of our ignorance and the necessity of a multidimensional perspective. First, the families of bulimics are very similar to the "psychosomatic families" of children suffering from asthma or repeated episodes of diabetic acidosis. This raises the as-yet-unanswered question of why bulimia and not some other disorder emerges in certain disorganized and unsupportive families (15, 21). Second, usually only one person in a "bulimic family" develops the disorder, and as yet we do not understand how the negative forces within such families come to focus on that child instead of another.

## Family Characteristics

It is important that education staff and other nonspecialists realize that the "chaos" and conflict described above may be found in the "good homes" of successful, well-respected people. The members of these families unwittingly promote con-

fusion about identity, body image, and the meaning of food by being emotionally overcontrolled, socially isolated, hyperconscious of appearances, and overinvolved with food preparation and eating habits as symbols of adequacy in female sex-role functioning (4, 27, 28).

Most of these families have acquaintances, but no close friends or institutional sources of emotional support. In a significant number of cases a college-educated mother is wedded to the role of housewife, although she derives little or no emotional sustenance from it. This sense of emptiness, studded with frustration and guilt, may manifest itself in a self-conscious abandonment of life outside the home and a compensatory overinvolvement with daughter's appearance and femininity.

As mother becomes increasingly divorced from herself, father is increasingly married to his job. The children love him very much and value his approval highly, but their affection may be tinged with resentment because his positive comments are usually contingent upon their performance and appearance, instead of being freely given for just being themselves. The children also tend to idealize his apparent strength and freedom, but find him to be physically absent a great deal and emotionally aloof when present.

Within this "very together family" an emphasis on the importance of appearances in getting ahead supersedes the ability of family members to support each other. For daughters, getting ahead may be defined in traditional terms (looking good—thin—and acting properly in order to catch a desirable husband) or in contemporary terms (getting good grades, winning in athletics, building a career, *and* catching a desirable husband—see Chapter 7). This overvaluation of appearances has two effects that encourage the development of bulimia. First, the children, particularly the girls, are taught that looking good to *others* is much more important than self-acceptance. Second, family members tend to monitor and compete with each other in order not to "look

bad." This establishes a very unhealthy situation in which family members are emotionally isolated but psychologically enmeshed in each other's lives. An atmosphere of mistrust, confusion, and competition is created, and the minimum definition of "looking good" is being thinner and more in control than someone else. Meeting this criterion results in the lonely elation of competitive victory; competitive failure brings the isolation and dejection of defeat. For the individual who is genetically vulnerable to severe emotional instability and culturally oriented to slenderness, such an atmosphere is bound to create problems in the management of feelings and food.

## A Very Cautious Conclusion

At this point it is very tempting to conclude that family conflict and disorganization set the stage for the impulsivity and identity problems observed in bulimia. Nevertheless, our enthusiasm should be constrained by three important points. First, there is tremendous variability in the characteristics and communication styles of the families studied (26, 28). Second, almost all studies rely on the perceptions of bulimic and comparison subjects as the principal means of characterizing family style. Two behavioral studies have corroborated the findings of self-report data, but there is still a great need for actual observation of families instead of reliance on the patients' opinions (17). Third, as is the case for anorexia nervosa, our current knowledge of familial characteristics associated with bulimia is based entirely on studies of families who have been coping with a severe eating disorder for some time. Until investigators tackle the imposing problem of prospectively observing interactions in a large number of high-risk families (white upper-middle-class families with daughters), it will be impossible to confirm whether the characteristics reported thus far predate or postdate the emergence of bulimia. Given these three qualifications, we must be content with the strong *possibility* that there is a significant risk of

bulimia if one grows up female in a middle- to upper-class family characterized by lack of unconditional support, emotional instability, interpersonal conflict, overemphasis on appearances, and complex contradictions about connection and separation.

## Individual Predispositions: Johnson's Affect Regulation Theory

The personality traits of bulimic individuals vary greatly (7, 9, 17). Nonetheless, based on the biological and familial predispositions discussed in the preceding sections, Craig Johnson and his colleagues at Northwestern University's Institute of Psychiatry believe that three interrelated personality characteristics place one at great risk for bulimia (16, 17). Johnson's theory is too recent to be well established, but it deserves considerable attention because it integrates common clinical observations, many research findings (see, for example, Gandour [9]), and the expertise of a leading researcher and clinician.

### Emotional Instability

The first individual risk factor is emotional instability. This is not the moodiness that characterizes adolescents at certain periods in their development, but rather a more profound deficit in the regulation of emotions. Many bulimic patients report long histories of swings in mood from elation following success to despair following perceived failure. Their tolerance for frustration and boredom is generally low, and they frequently feel at the mercy of the three "a's": anxiety, anger, and apathy. Emotional instability also manifests itself as impulsiveness in the form of promiscuity, substance abuse, or poorly thought-out changes in friends, classes, and lifestyle.

## Low Self-Esteem

A feeling of being at home in one's body and in control of one's emotions is fundamental to a healthy self-image. Consequently, the chronic emotional instability experienced by many bulimics produces repeated episodes of helplessness that eventually crystallize into low self-esteem. Lacking self-acceptance, the individual becomes extremely dependent on what others think and like (4, 27). This external orientation sounds pathological, but it is reinforced by two prominent aspects of the normal socialization of American women: (1) the extreme importance of external appearances; and (2) dependency on others, particularly men, for the definition and valuation of self.

## Disturbances in Interoceptive Awareness

The lack of internal control and self-determined values is intensified by the third characteristic of many bulimics, problems in interoceptive awareness. As is true for anorexics, many bulimics have trouble differentiating, identifying, and expressing internal states such as hunger, fatigue, or anger (see Chapters 2 and 8).

## The Effects of Predisposing Characteristics

Emotional instability, low self-esteem, and deficits in interoceptive awareness are interrelated characteristics that grow together as any one is intensified by a loss of control. All three leave the individual extremely dissatisfied with both her body and her mind, a feeling that is reinforced by constant exposure to the many aspects of our culture that portray women as hyperemotional sexual objects with inferior or even negligible intellectual powers

(3, 4). One might think that friendships or other interpersonal relationships could assuage self-dissatisfaction. One of the piercing ironies of bulimia, however, is that low self-esteem, emotional instability, and an external orientation make the bulimic hypersensitive to negative appraisal and imagined rejection by others (3). It is also hard for women in general to reach out to other women for support, because many of them have been socialized to believe that a thin and otherwise desirable body is a major weapon in the competition to attract men (3, 32).

As noted previously, many bulimic individuals have very high or completely unrealistic standards for achievement in the realm of career and family (4, 9, 17). Yet they are doomed to fall short of those high expectations, because they lack the self-control, the tolerance for frustration and ambiguity, and the authentic familial support that the attainment of excellence often requires (9, 17). Failure to meet extreme goals—such as becoming a "superwoman" (see Chapter 7—is virtually guaranteed, but responsibility for it is likely to be incorporated into an already negative self-image. Not surprisingly, the anxiety and shame generated by repeated discrepancies between ideals and actualities further undermine both self-esteem and the capacity for healthy relationships.

## Precipitants

### Dieting

According to Johnson, the predisposing characteristics lead many future bulimics to experience their "normal" bodies as inadequate containers of uncontrollable emotions, thoughts, and impulses (17). In many cases this negative and unstable body image is reinforced by cultural messages which insist that women reject their normal bodies (slim them, paint them, perfume them) and by

an individual history of weight fluctuations attributable to childhood obesity, dieting, overeating, puberty, and, occasionally, anorexia nervosa (4, 16, 32).

As is the case for anorexia nervosa, any of the following experiences may intensify dislike of the body to an unbearable degree while threatening the individual's sense of control over the important events in her life (4, 9):

1. A growth spurt or life change (going off to college) that produces rapid weight gain
2. Being teased about weight
3. A desire to join a program (dance or gymnastics or drill team) in which coaches and participants are often obsessed with slenderness, fitness, and competition
4. A traumatic loss or separation
5. The blossoming of heterosexual interest and/or a real or fantasied rejection by a boy
6. Confusion about sexuality and/or identity
7. Sexual harassment, sexual victimization, and/or physical abuse at home or at school
8. Observation of friends who are dieting "religiously."

Because the body is the locus of so many of her problems, and because women in our culture are strongly encouraged to develop their identities around the body and its sexual significance, the bulimic-to-be makes it the focus of efforts to "get it together." These days mastering the body means being thin, as seen, for example, in the widely held but nonsensical belief that for a woman to be physically fit, she must be thin (13; and see Chapter 7). Thus, for the bulimic-to-be, as for the anorexic, weight loss comes to be a concrete and externally defined indicator of self-regulation. Furthermore, weight loss results in many compliments and greater popularity, both of which are highly rewarding to sensitive people with low self-esteem.

If self-mastery = control of the body = dieting, then dieting = severe, obsessive, and prolonged restriction of food intake = total victory over hunger and the body. For vulnerable individuals—those who are emotionally unstable, lacking in self-confidence, and out of touch with their bodies—restrictive dieting is often the beginning of bulimia (9, 17).*

In fact, there is considerable evidence that a tendency to binge-eat is a normal consequence of dietary restraint (13, 25). This evidence is a fascinating and telling indictment of the sociocultural pressures that deify thinness (see Chapter 7). Before proceeding, contemplate these two questions: Should people who are overweight eat less than 2,000 calories per day? Should people whose weight is within acceptable medical limits lose a few more pounds to look and feel better? As implied in Chapter 7, the answer to both these questions is probably no.

## The Dangers of "Normal" Dieting

David Garner, Janet Polivy, and C. Peter Herman, all of the University of Toronto, are among the foremost proponents of the belief that *restrictive* dieting is a major risk factor in the development of bulimia (11, 13, 24, 25; and see also Bennett and Gurin [2]). Their theory integrates research on starvation (see Chapter 2) with a physiological concept called "weight set point." An individual's set point is the range of either total body weight or percent of body fat that is normal for that person according to the dictates of genetics, early feeding practices, and the body's need to maintain an internal equilibrium. The brain defends this "physiologically programmed weight level" (13, p. 532) in a manner akin to the homeostatic regulation of body temperature. Consequently, if weight falls significantly below the predetermined range, the brain will

*A small but significant percentage of normal-weight bulimics were at one time anorexic. This suggests that being anorexic is a significant risk factor for future bulimia (9).

adjust thinking, physiological functioning, and behavior to restore weight to the set point (13, 25). This compensatory tendency is particularly strong in females, the gender at greatest risk for bulimia, because they must maintain a fat/body weight ratio of approximately 17 percent in order to begin menstruation and 22 percent to restore it (1, 17).

This theory is controversial, for two reasons. First, it commits the blasphemy of stating that everyone is meant to be a certain weight in the same way they just *are* a certain height, even if the "normal" weight for a given individual is well above the "normative" range stipulated by weight-for-height tables.

Second, this theory redefines "dieting" to mean the normalization of food intake such that body weight moves in the direction of that "normal weight," that is, the set point. In practice, the weight considered normal and healthy for a given individual is the weight at which the individual stabilizes following sustained adherence to a daily program of three to six regularly spaced and well-balanced meals with a total daily caloric content of 2,000 to 2,400 calories (A. B. Enright, personal communication).* Although this meal plan may constitute a "diet" (dietary restraint) relative to the bulimic's (or any given person's) daily caloric intake, such a program is a far cry from what most people mean by a "diet" because its goal is to help people settle their weight "at a level that does not require chronic dieting to maintain" (13, p. 544). Thus, the purpose of this maintenance diet (for anyone) is to reach a weight at which the individual no longer experiences chronic hunger, emotional instability, the urge to binge-eat, and other damaging effects of semistarvation (13).

Most people, and particularly adolescents, would reject the set point theory in favor of the culturally sanctioned notion that all nonslender

*This is a general description of a maintenance diet. The program for any specific individual, bulimic or otherwise, should be determined by a registered dietician who understands set point theory.

people should diet restrictively to become thin (see Chapter 7). Nonetheless, Garner and others have marshalled what I consider to be incontrovertible evidence in favor of their contention that the type of restrictive dieting that has become normal for many teenage girls and some teenage boys is useless and dangerous (for a complete discussion see Bennett and Gurin, [2], Garner and others [13], Polivy and Herman [24], Wooley and Wooley [31]). There are many people who do not systematically monitor their body weight, food intake, or exercise, but who maintain a stable body weight. And, despite the claims of both quacks and respectable scientists, there is no reliable means of losing a significant amount of weight and *keeping it off*. Eating much less is certainly not the answer, for, counterintuitive as it may sound, scientific research refutes the proposition that overweight people eat more than nonobese people (31). Moreover, severe dietary restraint is a form of self-induced starvation that moves the individual's weight below—sometimes far below—the set point, producing a state tantamount to semistarvation. As we have seen, such deprivation produces many consequences—apathy, irritability, preoccupation with food, food hoarding, unusual taste preferences, excessive gum-chewing or coffee-drinking, and *binge-eating*—designed to conserve energy and motivate the individual to eat (see Chapter 2).

Ironically (and sadly), starvation also produces "hyperlipogenesis" (32)—the tendency of depleted fat cells to retain abnormally large amounts of fat during weight restoration. In essence hyperlipogenesis means that prolonged caloric restriction not only motivates binge-eating and reduces normal cues for satiation, but it also increases the probability that refeeding will result in excess accumulation of fat (32). These rebound effects are the basis of the bulimic's desperate and perpetual battle with hunger and weight.

Demonstrations of the dangers of severe dietary restraint are but small voices of sanity in an uproar of cultural madness concerning the

achievement of slenderness (11, 13). As noted in Chapter 7, women in particular are bombarded with messages emphasizing "sensible" or fanatical or even "natural" dieting as the solution to the problem of self-control and other forms of success. These exhortations to diet have a negative effect on many men and women (see Chapter 6), but the individual predisposed to bulimia is particularly ill-equipped to battle her body's defense of the weight set point. The apathy, distractibility, irritability, depression, rage, anxiety, and social withdrawal—in short, the emotional instability—produced by extended caloric restriction constitute the very same problems that dieting is intended to control (17).

Recall that deficits in impulse control are also part of the vulnerability to bulimia. This is extremely significant because extreme caloric restriction is essentially food deprivation, and food deprivation produces a powerful "impulse" called ***hunger***. This hunger drive threatens the self-control of the bulimic (or ***any*** chronic dieter) in two major ways. First, there is an extreme responsiveness to the sight, smell, and taste of food. Second, in response to prolonged and severe dieting, the body increases production of motilin, a hormone that facilitates gastric emptying and reduces satiation due to feeling bloated (25).

### *Counterregulation*

As part of the body's defense of a weight set point, intense hunger and reduced satiety produce a phenomenon called "counterregulation." Unlike nonrestrained eaters, ***dieters do not reduce their intake of food following ingestion of a large amount***; instead, they continue eating a lot—that is, they counterregulate or binge (25). In other words (17, pp. 263–64):

> Foremost among the compensatory behaviors that emerge in reaction to caloric deprivation is an increased vulnerability to binge-eating (rapid consumption of a large quantity of food in a short space of time).

To make matters worse, counterregulation (bingeing) is more likely to occur when the restrained eater (dieter) is emotionally distressed (25). This becomes the foundation of a vicious circle, because the emotionally unstable bulimic-to-be tends to amplify the irritability and restlessness that normally accompany intense hunger (severe dieting) (19).

## The Impasse

At this point the bulimic-to-be is once more at odds with her own body. Restrictive dieting (restraint = good versus normal eating = bad) initially enables her to control her body and approach "excellence" through the successful pursuit of thinness. But over time, as her body seeks to restore a normal weight, unhealthy (nonmaintenance) dieting evokes a biological imperative experienced as hunger and emotional instability. Thus, through pathological dieting the bulimic-to-be reaches what Johnson and Maddi (17) call a "psychobiological impasse": she is vulnerable to hunger, emotional distress, and failure, but her efforts to gain control of herself by extreme dieting only increase instability, self-disparagement, and, most of all, hunger.

## Disinhibition

It is obvious that, despite their hunger and tendency to counterregulate, restrictive dieters (and anorexics) are generally able to eat very small meals without losing control. For bingeing to occur, something must disinhibit the compensatory hunger generated by nonmaintenance dieting (25). Actually, many different experiences can overwhelm the bulimic-to-be's shaky defenses against counterregulation, including a "harmless" indulgence in a forbidden food, drinking alcohol or smoking marijuana, and a severe rejection or other stressor that is just "too much" (9, 17, 25). Sometimes a family

celebration or a friend at school will encourage the individual to participate in a group "pigout" (23, 32).

All these events produce the feeling "I am no longer in control." Using the dichotomous thinking of many dieters (and anorexics; see Chapter 8), any loosening of restraint is equated with having totally given in to gluttony. Just as unhealthy dieting is sustained by the belief "I am in control," bingeing (counterregulation) is unleashed by the thought "I've completely blown it now" (25).

## Perpetuators

In general bulimics experience binge-eating as a foreign and disgusting practice that they are powerless to resist (7, 17). Such helplessness does not terminate the behavior, however, because binge-eating has a complex set of positive and negative consequences whose net effect over time is to increase the probability of both bingeing and purging (17).

### Regulation of Emotion

At first bulimics try to control their emotional instability with restrictive dieting. Later, as semistarvation intensifies emotionality and then blends it with chronic hunger, they begin to transfer the regulation of emotion from dieting to bingeing. The trance-like state produced by rapid and mechanical gorging blots out anxiety, smooths out emotional peaks and valleys, and makes the seeming inevitability of rejection by other people irrelevant (7, 17, 20). Binge-eating also fills the emptiness of low self-esteem in the same way a mother's breast soothes a hungry baby (20). This form of self-nurturance is an especially powerful motive in people whose instability, mistrust of others, and tendency to self-sacrifice make it nearly impossible for them to receive emotional sustenance from interpersonal relationships (17). Paradoxically, all these palliative functions are

interwoven with the ability of binge-eating to obscure the underlying emotional dysfunction by becoming itself the focus of intense emotions, both good and bad (4, 17, 19, 23).

Although bingeing frightens the bulimic, it is initially experienced as a more or less acceptable sensation of being "swept away." This projective defense enables the bulimic to indulge in a stimulating release from dietary and emotional inhibition while blaming the disturbing loss of control on the irresistible power of a tempting food or a rejecting person, rather than on a lack of "will power" (17). Denying responsibility in this manner also sets the stage for a heroic reentry into the process of self-control through reestablishment of rigid dieting, strenuous exercising, intense studying, or other forms of self-control (20, 23).

As the tensions in this overcontrolled life begin to mount, and as the rewards of "controllable losses of control" become more salient, the bulimic starts to use binge-eating as an intentional regulator of the aversive emotions that continually threaten her ability to "keep it together" (9, 17). Thus, over time the binges develop into a predictable response to tension, boredom, and loneliness, and many bulimics eventually plan them on a weekly or daily basis. At this stage, purging comes to occupy a more prominent place in the cycle (see below), because the bulimic rationalizes the planning of binges in accordance with her confidence in the compensatory purge (32).

## Impulse Expression

Since many bulimics are impulsive as well as emotional, episodes of private binge-eating offer an ostensibly safe means of "letting go." Depending on the individual, binge-eating can express frustration, sexuality, anger, defiance, or simply a need to "cut loose" in a manner that has none of the immediate moral, physical, or legal consequences of other forms of impulsivity such as pro-

miscuity, drug abuse, or interpersonal violence (17). Seen from another angle, bingeing and purging provide an initially controllable superstructure of impulsivity for people who are prone to boredom and confusion about their feelings (23). Within families characterized by an inability to let go of their daughters and a strong emphasis on weight control, binge-eating can also serve as a private form of autonomous protest (17).

## Purging

Binge-eating has many immediate rewards for the bulimic. Once the episode has ended, however, the bulimic usually feels guilty, disgusted, panicky, and, occasionally, suicidal (7, 9, 17, 20). Not only has she lost control (been "bad"), but she is terrified by her conviction that binge-eating will lead to weight gain. In her eyes the inevitable accumulation of fat will be public evidence that she is out of control and otherwise worthless.

This exaggerated interpretation points to the fact that bulimics often operate according to the same types of irrational attitudes and beliefs that twist the thinking of anorexics (see Chapter 8): I must diet to be good; I have no self-control, so either I must diet strenuously or I might as well give up; any self-indulgence is a sign of weakness; eating makes me feel fat, so I must be getting fat (8). Binge-eating puts tremendous pressure on this system of beliefs because it highlights a contradiction: severe dietary restraint = control and weight loss = good; binge-eating = pleasure and tension regulation; binge-eating = loss of control and weight gain = bad (17). Thus, the bulimic is faced with a very important question from the standpoint of psychological equilibrium: Is there a way to "have her cake" and not have it too? For some bulimics the answer is purging, usually in the form of self-induced vomiting, and the trap is sprung.

The thought of purging is repellent to most people, but to the binge-eater it is very attrac-

tive as a controllable, immediate, and aggressive means of undoing excessive caloric intake. Moreover, in *the short run* it works extremely well (22, 32). In fact, many bulimics lose weight steadily for a long time after they begin purging. Of course, this reduction is highly valued and as such may be the factor that transforms episodic binge-eating into a vicious binge-purge cycle. In *the long run* self-induced vomiting may actually contribute to *weight gain* because this form of purging increases the severity and frequency of binge-eating while eliminating only two-thirds or so of the calories consumed (A. B. Enright, personal communication; [13]).

Parallel to binge-eating, self-induced vomiting serves a number of purposes in addition to the attempt to reverse the effects of gorging (17, 20). Cleansing the system in an aggressive manner is a concrete reassertion of control that can simultaneously discharge angry feelings toward others and self. Purging also functions as penance for the guilt created by impulsivity, and after a purge many bulimics feel alert, purified, and peaceful. Conversely, for the subgroup of bulimics who are severely troubled by emotional instability, dependency on others, and a crushing sense of personal ineffectiveness, both purging and bingeing are forms of self-mutilation whose pain combats their feeling of inner deadness (17).

The other forms of purging—laxatives, diuretics, prolonged fasts, diet pills—may also serve multiple purposes. Consciously, they are used to counteract the effects of a binge. Unconsciously, they may serve as self-punitive measures and as legitimizers of continued bingeing.

As noted above, in the early phases of the disorder bingeing is quite reinforcing because it reduces and thereby controls both hunger and unpleasant emotions. As it becomes habitual and uncontrollable, however, its net effect is to increase tension and body weight. This means that in the later stages of bulimia the all-important function of tension regulation will be transferred to purging. No matter how repugnant self-induced vomiting may

appear to us, its ability to reduce tension and increase the sense of dedication to slenderness is so potent that purging often becomes the sustaining factor in bulimia (16, 17, 32). Some bulimics literally binge so that they can purge, an outcome that only increases the probability of bingeing and, ironically, of weight gain.

## The Distortion of Hunger and Satiation

Given the relationship between dietary restraint and the distortion of hunger and satiation (counterregulation), one might expect that a cessation of bingeing and purging and a restoration of normal body weight would stabilize the experience of hunger. Unfortunately, this is not the case. Chronic bulimics have an increased appetite, particularly for sweets, even after they have eliminated bingeing and purging and have achieved a healthy body weight (32).

The distortion of hunger and satiety is very significant in the perpetuation of bulimia. A voracious appetite makes it exceedingly difficult for the bulimic to overcome her fear that she will become grotesquely fat if she eats "normally." In addition, the persistence of extreme hunger for several weeks or even months is very discouraging for the therapist and client when they have worked so hard to stop the bingeing and purging (32).

It is very likely that residual voraciousness is not a function of emotional factors. It is probably due to changes in physiology and learning that impair the body's ability to terminate eating once it has begun (32).

Most bulimics eat very little between their episodes of bingeing on sweets or carbohydrates. This means that they subsist for long periods on sugars that are absorbed to a small degree before purging. The body learns to adjust to this state of affairs by releasing the hormone insulin immediately after eating begins. Insulin contributes to the onset

of bingeing by increasing appetite and promoting fat storage.

By definition, a person who binges continues to eat long after he or she feels full. Psychological research has demonstrated that, although the hypothalamus regulates satiety, people need to learn what combination of external perceptions (such as tastes or textures) and internal signals (metabolic feedback) indicates that they have eaten enough. Bingeing and purging pervert this process of learning to "feel full," because the bulimic's body "learns" that eating huge amounts of foods high in sugar or carbohydrates provides very few calories (32). In effect, the bulimic's body forgets how to regulate consumption of balanced meals while it learns that enormous amounts of sweet or fatty foods are necessary to produce satiation.

## The Vicious Circle

The relationship among the predispositions, precipitants, and perpetuators of bulimia is shown in Figure 9–1 (adapted from Johnson and Maddi [17]). Another way to summarize much of the material in this chapter is to examine the origin and outcome of the vicious circle that imprisons bulimics once bingeing and purging become regular features of their lives (7, 10, 17, 20, 32).

### Origin

This trap originates in the bulimic's need to be in control of her emotions and her body, and thus herself. At first restrictive dieting meets this need, but eventually it leaves her hungry and depleted in a physical and emotional sense. Semistarvation also renders her less capable of experiencing pleasure in any activity other than weight loss.

Binge-eating provides a release for these tensions, but it makes her feel anxious and guilty about helplessness and gaining weight. Having

SOCIOCULTURAL FACTORS

Glorification of thinness and perfectionism
Stigma against obesity
Emphasis on uniqueness
Weakening of external restraints
Sex-role ambiguity for women
Femininity = appearance

FAMILIAL FACTORS

Family history of affective disorder (depression or mania) and/or alcohol abuse
Middle- to upper-class parents magnify cultural emphases
Chaotic and disengaged: conflict, stress, contradictory communication about autonomy
Emotional isolation and unexpressiveness

INDIVIDUAL PREDISPOSITIONS

Problems with autonomy, separation, and identity
Emotional instability: variable moods; impulsivity; low tolerance for anxiety, frustration, boredom; episodes of depression and/or mania
Low self-esteem: sense of ineffectiveness; self-criticalness; competitive but dependent; perfectionist; high interpersonal sensitivity and lack of internal standards; body dissatisfaction
Weight problems (including anorexia nervosa) as a child or adolescent
Deficits in interoceptive awareness and flexible thinking

PRECIPITATORS

Adolescent conflicts
Separation, loss, rejection
Interest in dance or sports

DECISION TO DIET

Dissatisfaction with body, self, and life
Threat of helplessness and failure

EFFECTS OF WEIGHT LOSS

Sense of control over self/others
Reinforcement from others and/or self

Blossoming of heterosexuality
Sexual victimization
Observation of peers who are dieting
Failure
Loneliness, boredom, anger

Perfectionist need for control and success
Familial and cultural emphasis on slimness and external appearances
Competition with others

Fear of weight gain
Intensified dieting
Impasse: dieting = control/success + instability and voracious hunger

PERPETUATING EFFECTS

Distortion of hunger and satiation
Frequent and habitual bingeing/purging
Physical illness and weakness
Emotional instability
Narrowing of interests
Interpersonal conflict and isolation
Guilt, shame, anxiety
Failure and depression
Distorted body image and all-or-none thinking

PURGING

Undoing of the binge
Reassertion of control
Expression of anger
Penitence
Tension reduction
Legitimization of bingeing
Sense of dedication to weight control

BINGE-EATING

Regulation of emotion
Expression of erotic and aggressive impulses
Self-controlled narrowing and dissolving of life's structure
BUT also loss of control, panic, fear of discovery

Figure 9–1. A Multidimensional Model of Bulimia

*Source:* Johnson and Maddi (17).

reached this impasse, the bulimic usually discovers self-induced vomiting, laxatives, or diuretics. These appear to be a miraculous solution to her problem, because they eliminate the contents of a binge and they result in weight loss. Purging is also a temporarily successful form of self-deception in that it can serve as a dramatic first step in the bulimic's attempt to reestablish "normal" self-regulation by being "perfect" in weight control, school, relationships, and so on.

The biological pressures (hunger and fatigue) and the psychological pressures (self-consciousness and guilt) of this compensatory restraint are simply too great for a person who is already susceptible to emotional instability and impulsivity. Thus, the stage is set once more for bingeing and purging and, further, more desperate restraint. After a while, dieting, bingeing and purging become an autonomous chain of habits. In severe cases, an automatic link with emotions or times of the day is forged, and the body adjusts to a "diet" consisting almost exclusively of forbidden foods. When this happens, bulimic behavior becomes divorced almost completely from the experience of hunger, deviations from set point, or emotional distress (26).

## Outcome

Ultimately, bulimia accentuates the very problems it was "designed" to overcome (16, 20, 22; and see Chapter 4). Physically, the bulimic becomes weak and sickly. In addition, to the bulimic's horror, frequent bingeing and purging often result in a net gain in body weight. Socially, the bulimic loses authentic contact with others because her self is overshadowed by a continual and private struggle between hunger, eating, fear of obesity, and a deep sense of shame and worthlessness. Psychologically, the hope of control and integration becomes the reality of helplessness and disintegration. Moreover, unlike many anorexics, most bulimics are all too aware that they are living a lie. Underneath a

normal and often very attractive exterior, bulimia has eroded their self-esteem, their sense of purpose, and their basic ability to experience and express all the emotions that make us human.

The tragedy of bulimia is expressed with poignancy by Wooley and Wooley (32, p. 398):

> Arriving for treatment, these women struggle to tell us how life in their bodies is experienced—as a series of nightmarish transitions from relative calm to revulsion and loathing; how tenuous and fragile is their capacity for control; how much effort they expend to maintain control for even a few hours; and how purging, for all its horrible effects, is all that stands between them and an anticipated loss of all self-worth. They accept the pain of purging rituals gladly, as the only remaining test of endurance they know they can pass.

## Conclusions and Implications

### A Multidimensional Perspective

*Conclusion.* All the conclusions and implications concerning the risk factors of anorexia nervosa (see pp. 203–8, Chapter 8) also apply to the "causes" of bulimia. Bulimia too *must* be understood as a complex and variable psychobiological disorder. There is no doubt that construing it as an "illness" is helpful in tempering anger and motivating the search for proper medical and psychological treatment. Nevertheless, it is a mistake to allow this categorization to obscure the interplay between biological, personal, familial, and sociocultural factors in the predisposition, precipitation, and perpetuation of bulimia. Moreover, it is essential to keep in mind that each bulimic (and anorexic) person is different with respect to the pattern of symptoms, the relative strengths of the factors discussed in this chapter, and the healthy aspects of personality that pave the road to recovery—intelligence, coping skills, creativity, and so forth.

*Implications.* Teachers should refrain from offering simplistic pronouncements about the "cause" of bulimia. For example, bulimia is not "just a form of depression." If students want information about the origins of bulimia, allow ample time to consider the transactions among such factors as self-esteem, autonomy, fashion, dieting, set-point theory, and interpersonal relationships. Such preparation is more than a matter of good scholarship. Given that sociocultural and interpersonal factors play a role in the cause and maintenance of bulimia, there is every reason to believe that teachers, both as caring people and as representatives of an influential social institution, can make a significant contribution to the prevention of bulimia.

## A Sensitive Perspective

*Conclusion.* The multidimensional perspective definitely points to the family as one of the "villains" in the crime of bulimia. As one section of this chapter states, a major contributor to bulimia is marital discord between a frustrated, weight-conscious, and depressed mother and a workaholic, emotionally aloof husband (see, for example, Boskind-White and White [4]). It is important to remember that this is not true of all "bulimic families"; in fact, the variability in family structure and dynamics is at least as strong as the consistencies extracted by researchers. Even if it is true of a particular family, the multidimensional perspective, albeit complex, is simply too limited to provide an accurate and sympathetic picture of the historical and social context that shapes the functioning of parents and grandparents.

*Implications.* When evaluating other persons, we tend to overlook the context of their behavior and attribute their actions to internal dispositions (32). This chapter, as well as the previous one, is an attempt to reverse this attributional bias in the perception of bulimics (and anorexics) by elucidating the context of their seemingly irrational behavior. To be consistent and fair, we must acknowl-

edge, for example, that the mothers of today's bulimics are themselves the products of complex historical, social, and personal factors that, among other things, have influenced the ways they think about their bodies, their sexuality, and their sex roles (3, 4).

Teachers should endeavor to discuss familial risk factors without blaming the family in a one-sided manner. Remember that the concept of a risk factor means that it will be present in varying degrees in different instances of the disorder and completely absent in some. Moreover, should the family be clearly to blame in a certain case, respect and sensitivity are even more necessary because the family is the most important source of support for a youngster in trouble.

## Bulimia and Anorexia Nervosa

*Conclusion.* A comparison of the risk factors for bulimia and anorexia nervosa highlights the complex and ambiguous relationship between the two eating disorders. On the one hand, two facts support a distinction between bulimia and restricting anorexia nervosa. First, there are normal-weight and obese bulimics who have never been and will never be anorexic. Second, research indicates that bulimic anorexia seems to be more closely related to normal-weight bulimia than to restricting anorexia nervosa on a number of variables.

On the other hand, there is evidence of a strong relationship between the two disorders. Being anorexic is a risk factor for subsequent normal-weight bulimia, and vice versa. More important, a comparison of the two multidimensional models reveals many apparently identical risk factors (see Table 9–1). Perhaps it is best at this point to view anorexia nervosa and bulimia, not as dichotomous syndromes, but as general "landmarks" on a spectrum of "eating disorders" ranging from restricting anorexia nervosa to bulimia in people of various body weights (30; and see Figure 1–1 in Chapter 1).

## Table 9–1. Shared Predispositions, Precipitants, and Perpetuators of Bulimia and Anorexia Nervosa

### PREDISPOSITIONS

*Sociocultural*

Glorification of thinness and fanaticism
Stigma against obesity
Emphasis on uniqueness
Weakening of external restraints
Sex-role ambiguity for women
Femininity = appearance

*Familial*

Middle- to upper-class status
Family history of depression, substance abuse, weight/eating disorders
Family magnifies sociocultural emphases
Conflicting and contradictory information about identity and autonomy
Distorted, dysfunctional, and stressful family system
Lack of encouragement for expression of emotions

*Personal*

Female gender
Weight problems as child or adolescent
Problems with identity, separation from parents, and autonomy
Interpersonal sensitivity and dependence on others for approval
Denial of inner needs and feelings
Perfectionism and "all-or-none" thinking
Disturbances in body image and interoceptive awareness

### PRECIPITANTS

| *Events and Experiences* | (lead to) | *Bases for the Decision to Diet* |
|---|---|---|
| Adolescent conflicts (e.g., autonomy versus dependence) | | Dissatisfaction with body, self, and life |
| Separation, loss, rejection | | Threat of helplessness and failure |
| Interest in dance or sports | | Perfectionist need for control and success |
| Blossoming of heterosexuality | | Familial and cultural emphasis on slimness and external appearances |
| Observation of peers who are dieting | | Competition with others |
| Failure | | |
| Loneliness, boredom, anger | | |
| Sexual victimization | | |

### PERPETUATORS

Distortion of hunger and satiation
Perceptual disturbances and dichotomous thinking
Interpersonal conflict and isolation
Self-induced vomiting
Narrowing of interests
Gastrointestinal disturbances
Ineffectiveness, guilt, anxiety

*Implications.* It is not known with certainty why some girls develop bulimia instead of anorexia nervosa. If this question arises, it is best to point out that bulimic girls tend to be more emotionally unstable, more attuned to their emotional distress, more extroverted, and less likely to have the internal controls and obsessive personality features that enable the anorexic to regulate emotions and caloric intake in a rigid fashion (1, 30).

Yet this distinction or any other should be balanced by an acknowledgment that bulimia and anorexia nervosa share a number of similar features (see Chapter 1) and risk factors. Although it is not an intellectually satisfying state of affairs for teachers, students, or writers of books about eating disorders, the fact remains that the relationship between anorexia nervosa and bulimia is ambiguous enough to warrant discussion of both meaningful differences and very important similarities.

## References


1. Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia.* Baltimore: Johns Hopkins University Press, 1985.
2. Bennett, W. G., and Gurin, J. *The Dieter's Dilemma: Eating Less and Weighing More.* New York: Basic Books, 1982.
3. Boskind-White, M. "Bulimarexia: A Sociocultural Perspective." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 113–26. New York: Brunner/Mazel, 1985.
4. Boskind-White, M., and White, W. C. *Bulimarexia: The Binge/Purge Cycle.* New York: W. W. Norton, 1983.
5. Bruch, H. *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within.* New York: Basic Books, 1973.
6. Carroll, B. J. "The Hypothalamus-Pituitary-Adrenal Axis in Depression." In *Handbook of Studies on Depression*, edited by G. D. Burrows, pp. 325–41. New York: Excerpta Medica, 1977.
7. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion.* New York: Doubleday, 1983.
8. Fairburn, C. G. "Cognitive-Behavioral Treatment for Bu-

limia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 160–92. New York: Guilford Press, 1985.

9. Gandour, M. J. "Bulimia: Clinical Description, Assessment, Etiology, and Treatment." *International Journal of Eating Disorders* 3 (1984): 3–38.
10. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.
11. Garner, D. M. "Why Obesity Should Not Be Treated." Workshop presented at Fourth Annual National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.
12. Garner, D. M.; Garfinkel, P. E.; and O'Shaughnessy, M. "The Validity of the Distinction Between Bulimia With and Without Anorexia Nervosa." *American Journal of Psychiatry* 142 (1985): 581–87.
13. Garner, D. M., and others. "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 513–72. New York: Guilford Press, 1985.
14. Johnson, C., and Connors, M. E. "Treatment of Bulimia: A Review." *Psychological Bulletin* (in press).
15. Johnson, C., and Flach, A. "Family Characteristics of 105 Patients with Bulimia." *American Journal of Psychiatry* 142 (1985): 1321–24.
16. Johnson, C.; Lewis, C.; and Hagman, J. "Bulimia: Review and Synthesis." *Psychiatric Clinics of North America* 7 (1984): 247–73.
17. Johnson, C., and Maddi, K. L. "The Etiology of Bulimia: Biopsychosocial Perspectives." In *Adolescent Psychiatry*, vol. 13, edited by S. C. Feinstein and others, pp. 253–73. Chicago: University of Chicago Press, 1986.
18. Johnson, C.; Stuckey, M.; and Mitchell, J. E. "Psychopharmacology of Anorexia Nervosa and Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 134–51. Minneapolis: University of Minnesota Press, 1985.
19. Josephson, A. M. "Psychodynamics of Anorexia Nervosa and Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 78–101. Minneapolis: University of Minnesota Press, 1985.
20. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid

Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

21. Minuchin, S.; Rosman, B.; and Baker, L. *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge: Harvard University Press, 1978.
22. Mitchell, J. E., and Pyle, R. L. "Characteristics of Bulimia." In *Anorexia Nervosa and Bulimia: Diagnosis and Treatment*, edited by J. E. Mitchell, pp. 29–47. Minneapolis: University of Minnesota Press, 1985.
23. Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*. New York: Van Nostrand Reinhold, 1983.
24. Polivy, J., and Herman, C. P. *Breaking the Diet Habit*. New York: Basic Books, 1983.
25. Polivy, J., and Herman, C. P. "Dieting and Bingeing: A Causal Analysis." *American Psychologist* 40 (1985): 193–201.
26. Pope, H. G., Jr., and Hudson, J. I. *New Hope for Binge Eaters: Advances in the Understanding and Treatment of Bulimia*. New York: Harper and Row, 1984.
27. Rizzuto, A. "Eating and Monsters: A Psychodynamic View of Bulimarexia." In *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*, edited by S. W. Emmett, pp. 194–210. New York: Brunner/Mazel, 1985.
28. Schwartz, R. C.; Barrett, M. J.; and Saba, G. "Family Therapy for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 280–306. New York: Guilford Press, 1985.
29. Streigel-Moore, R. H.; Silberstein, L. R.; and Rodin, J. "Toward an Understanding of Risk Factors for Bulimia." *American Psychologist* 41 (1986): 246–63.
30. Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.
31. Wooley, S. C., and Wooley, O. W. "Obesity and Women—I. A Closer Look at the Facts." *Women's Studies International Quarterly* 2 (1979): 67–79.
32. Wooley, S. C., and Wooley, O. W. "Intensive Outpatient and Residential Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 391–430. New York: Guilford Press, 1985.
33. Worchel, S., and Cooper, J. *Understanding Social Psychology*. 2d ed. Homewood, Ill.: Dorsey Press, 1979.

CHAPTER 10

# The Role of School Employees in the Prevention of Eating Disorders

This book has two interrelated themes. First, eating disorders are multidimensional problems that emerge from a very complex transaction between numerous influences: genetics, neurophysiology, personality, the family, peers, the culture, and misinformation about nutrition and weight management. Second, since school employees play very important roles in the transmission of culture, the shaping of peer interactions, and the development of knowledge about the body and the self, they can have a significant impact on the prevention of eating disorders.

Traditionally, the mental health profession recognizes three types of prevention (5, 19). *Primary prevention* eliminates or reduces sociocultural factors (such as the stigma attached to being overweight, or misconceptions about the body's regulation of weight) that increase the risk of eating disorders. Thus, primary prevention involves the monumental task of preventing eating disorders by changing the behavior of those groups—students; teachers, as well as the entire school staff; parents; psychologists; dieticians; advertisers—that influence body image, self-esteem, eating habits, coping skills, and so forth. *Secondary prevention* is the early identification, accurate referral, and prompt treatment of individuals in the initial phases of anorexia nervosa or bulimia. Its goal is to prevent acute problems

from becoming severe and chronic eating disorders. Finally, *tertiary prevention* corresponds to the full-scale treatment of severe eating disorders. Effective treatment will prevent the individual from having subsequent episodes.

The guiding principle of this book is that all school employees can contribute significantly to primary and secondary prevention, and therefore treatment will not be discussed. Educated and concerned teachers will have the greatest impact on primary and secondary prevention in the classroom and in the role of adviser. Any member of the school staff who has a special interest in preventing eating disorders may also wish to become involved in educating the community.

## The Teacher as Educator in the Classroom

### General Principles

Since I do not presume to tell experienced teachers what exactly to do in the classroom, let me begin with a list of general principles for discussing eating disorders with students.

#### *Self-Examination*

It is very important that teachers thoroughly examine their motives for presenting information about eating disorders and their attitudes toward eating and weight. For example, be as honest as possible in making a list of *all* the reasons you are interested in anorexia nervosa and bulimia. This exercise will probably lead to a consideration of your own body image, self-concept, eating patterns, and exercise habits. Next, examine carefully your attitudes about sex roles and about underweight, "normal-weight," and overweight people (20). Does your language overtly or subtly discriminate against people who are overweight? For example, when you hear the word "slob," does your mind automatically

append "fat" to it? Do you believe that women ought to be more concerned with appearance and less concerned with achievement than men? If you are going to ask your students to explore such issues, it is imperative that you do the same. This will make you a more sensitive listener. It will also ensure that your lifestyle and your nonverbal communications do not undo your statements about the importance of personal substance over external appearances.

### *Sensitivity*

Eating, weight, and self-concept are emotionally charged topics for adolescents, particularly girls and overweight boys. Teachers can demonstrate sensitivity to these authentic concerns and fears by pointing out the difficulties involved in discussing the subject and by allowing students ample time to comment or not comment as they see fit. The sensitive teacher will also want to introduce the topic in a nonthreatening way. The exercise shown in Figure 10–1 is excellent in this respect, as is consideration of individuals who accept their ample girth, such as William "the Refrigerator" Perry, Nell Carter, and Garfield the Cat.

### *Setting Limits*

Given the high prevalence of eating disorders and unhealthy eating habits in adolescents (see Chapter 6), it is virtually certain that there will be at least one student in the class with disordered eating. Teachers should make it clear that their discussion of eating disorders is didactic, not therapeutic. Before the end of the (first) day, students should be given a list of community or nearby resources for the treatment of eating disorders. It is also an excellent idea for teachers to coordinate lessons on anorexia nervosa and bulimia with the opportunity for students who are concerned about themselves or others to speak confidentially with a school counselor who is informed about eating disorders and resources for treatment.

*Fat? Skinny? or Just Right?*

Part I.

My favorite food is

_____

My favorite food group is

_____

My favorite meal is

_____

Why do I look forward to that meal especially?

_____

_____

Family food rituals (traditions):

_____

_____

What messages have I heard from my parents about food and eating?

_____

_____

Do I eat only when I'm hungry?

_____

If not, what are some of the other reasons?

_____ _____

_____ _____

_____ _____

Does anyone in my family have a weight problem?

_____

Part II.

If you could change your figure, what would you change?

_____

On a scale of one to ten, indicate your degree of satisfaction about your body image.

1 2 3 4 5 6 7 8 9 10

What do you think is the ideal weight for your height (the weight at which you feel most healthy, energetic, happy, etc.)?

_____

Think of some ways that advertising gets us to think that thin is beautiful?

_____

_____

Figure 10–1. A Nonthreatening Exercise for Introducing the Topic of Eating Disorders

*Source:* Reprinted from J. M. Pratt, "Junior High and High School." In *Anorexia and Bulimia: A Handbook for Counselors and Therapists*, by P. A. Neuman and P. A. Halvorson. Copyright © 1983 by Van Nostrand Reinhold Company. Reprinted with permission.

Part III. Concept of BODYMIND—a delicate balance:
Can you read your body's messages? _____
Can you tell the difference between
hurt and angry? _____
tired and hungry? _____
bored and hungry? _____
restless and hungry? _____
Identify your "comfort foods."
_____
_____
How do we get in trouble with food?
_____
_____

Figure 10-1—*Continued*

## Eating Disorders and the Basic Curriculum

There are many ways to work material about eating disorders into the curriculum (see Table 8-1, p. 204). These approaches can be divided into two general categories: (1) curricula on eating disorders, and (2) special topics that incorporate important aspects of eating disorders.

### *Curricula on Eating Disorders*

Andrea Bull-McDonough, an education consultant for Anorexia, Bulimia Care, Inc. (ABC), of Massachusetts, informs me that at the time of this writing two curriculum guides are available for teachers who wish to develop a unit on eating disorders:

*Teaching About Eating Disorders, Grades 7–12.* This 23-page pamphlet is written and published by the Center for the Study of Anorexia and Bulimia, 1 West 91st Street, New York, NY 10024 (212–595–3449). In addition to facts about the nature and treatment of eating disorders, the first half contains concise information about the emotional uses and meaning of food, a sociological perspective

on women, and the relationship among body weight, body size, and beauty. The second half provides a list of general questions and activities to facilitate the teaching of these topics. Ms. Bull-McDonough (in a personal communication) feels that this pamphlet is an excellent resource for teachers who think they might be interested in developing their own lesson plans covering all or some of the topics listed.

*The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12.* This set of five lessons was written by the author and edited by several experts from the National Anorexic Aid Society (6). Quoting from the introduction:

> [This] lesson plan attempts to explain anorexia and bulimia within the context of topics discussed in middle school and high school health, science, and Quest courses. These topics include cultural values; the transmission of values; eating (refusing to eat) as a social phenomenon; fears and anxieties; positive and negative styles of coping; the meaning of abnormality; the self-defeating nature of abnormal behavior; the social psychology of helping; the ethics of helping; and the prevention of mental illness. (p. 2)

In other words, this lesson plan attempts to minimize the sensationalism attached to eating disorders while maximizing the probability that discussions of anorexia nervosa and bulimia will touch on a number of topics relevant to the teacher's basic role in educating adolescents and supporting their development. Figure 10–2 shows a sample page. Information about the lesson plan is available from the National Anorexic Aid Society, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

### *Special Topics*

As noted in Chapter 8, the multidimensional models of anorexia nervosa and bulimia indicate that eating disorders are related to topics ranging from the biology of weight regulation to the influence of teen magazines on fashion and eating habits (see Table 8–1). This means that biology teachers can discuss set-point theory (see Chapter 9,

*II. Objective: STEREOTYPING AND WEIGHT*

To have students think about values pertaining to weight, and look at sexual differences and biases.

To encourage students to look beyond body size and appearance to find value in others.

*Recommended Time:* 5 minutes

*Aids:*

a. Ask for students' stereotypes about overweight males and females. These can be listed on the board according to the physical = social = psychological scheme.

*NOTE:* Be sure care is taken for the feelings of the class members who are considered to be overweight by their peers.

b. Point out sexual differences as they occur. For instance people tend to see weight as crucial for girls' attractiveness, less so for boys'.

c. Use Overhead 2: [STEREOTYPING AND WEIGHT]

*Questions:* In our culture, is it better to be overweight or underweight? Why do people care so much about their weight?

---

*Suggested Topics*

In keeping with the paradigm of Physical-Social-Psychological Values, here is a scheme for exploring how our stereotypes about overweight people affect our attitudes towards individuals:

| | Where our culture values: | We tend to believe overweight people are: |
|---|---|---|
| PHYSICAL | health | unhealthy |
| | activity | lazy |
| | coordination | uncoordinated |

Figure 10–2. Sample Page from Lesson Plan

*Source:* Reprinted from M. P. Levine, *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12.* Edited by A. B. Enright, N. Kayne, and C. Tootell. Copyright © 1983 by the National Anorexic Aid Society. Reprinted with permission.

| | | |
|---|---|---|
| SOCIAL | Where our culture values:<br>friendliness<br>respect | We tend to believe overweight people are:<br>over-social, or<br>withdrawn |
| PSYCHOLOGICAL | Where our culture values:<br>having it together<br>purposefulness<br>rapid and effective<br>being in control | We tend to believe overweight people are:<br>disorganized<br>aimless<br>slow, ineffective<br>out of control |

*Stereotypes* are fixed ideas about a group of people, which are not necessarily true for individuals within the group. These ideas reflect our values, not what is actually true. Stereotypes can be positive (the "halo" effect) but are usually negative.

Figure 10-2-*Continued*

pp. 221-23) and its implications for hunger; history and art teachers can examine changes in the concept of beauty and fashion through the centuries; and social studies and speech teachers might encourage students to study advertising's role in the glorification of thinness as a form of propaganda (14). The range of special topics that might be discussed is limited only by the creativity of teachers.

### *Resources for Preparation*

Whether or not the teacher uses a curriculum guide, it is a good idea to read at least one book that covers anorexia nervosa or bulimia in more detail or from a perspective different from this one. Appendix II contains a list of useful books and articles. Of these I highly recommend the following as excellent supplements to the material in this book:

Boskind-White, M., and White, W. C., Jr. *Bulimarexia: The Binge/Purge Cycle*. New York: W. W. Norton, 1983.

Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978.

Crisp, A. H. *Anorexia Nervosa: Let Me Be*. Orlando, Fla.: Grune and Stratton, 1980.

Kinoy, B. P., and others. *When Will We Laugh Again? Living and Dealing with Anorexia Nervosa and Bulimia*. New York: Columbia University Press, 1984. (See Table 10–2)

Levenkron, S. *The Best Little Girl in the World*. Chicago: Contemporary Books, 1978. (See Table 10–2)

### *Resources for the Classroom*

*Invited Speakers*. In some communities excellent speakers can be obtained at no cost by contacting the nearest mental health association, community mental health center, hospital, college counseling center or psychology department, an eating disorders association, or any school employee who has a special interest or experience in the area of eating disorders. The speaker may be a therapist, a specialist (such as a dietician), or a recovered patient. Even though the person may be an expert, do not hesitate to ask for an outline of the talk in order to be certain the speaker does not inadvertently glorify the disorder or stigmatize overweight people.

*Films*. Appendix II contains a list of several films. I use *Dieting—The Danger Point* (CRM/McGraw-Hill Films, 20 minutes) in my college psychology courses as an excellent introduction to eating disorders and the role of the media. It contains some footage of a severely anorexic woman clad only in a bikini. Teachers should be sure to preview this or any other film to determine its suitability for the audience as well as for their educational aims.

## The Teacher as Model

All school employees can contribute to the prevention of eating disorders by conducting themselves in a manner that communicates self-acceptance and the irrelevance of body weight or shape for enjoyment of a wide variety of activities (1, 12). The teaching and advising functions will be strengthened considerably by attitudes and behaviors that repeatedly say: "Regardless of my weight and shape, I like myself. I do not need to *drive* myself to be thinner or more accomplished. It would not matter if I gained weight or lost weight; I would still be me, a worthwhile person."

## The Special Role of Coaches

If a crucial component of prevention is the deemphasis of slenderness and the promotion of self-esteem via self-acceptance, then it is reasonable to believe that coaches and dance teachers can help prevent eating disorders (4). Boys and girls should be allowed to dance and to participate in athletics, regardless of their body weight or shape. Being "in shape" to participate should not be construed as a need to mortify the flesh. That is, students should not be driven to excel in a manner that encourages them to treat their bodies as enemies to be conquered, and weight loss should not be advocated as a solution to the problem of improvement. In this regard weekly weigh-ins and the postings of body weights should be discontinued. Moreover, dance instructors and coaches of women's teams should not give advice about diets without ascertaining the student's motivation, particularly if the request for information closely follows an experience with failure or rejection. Similarly, wrestling coaches need to consider the potential damage created by the need to "make weight" and by the social transmission of extreme tactics for temporary weight loss.

These suggestions are based explicitly on the goal of healthy participation in athletics and dance. Thus, some coaches may ignore them out of hand as being hopelessly out of step with current conceptions of how to develop a "winning" program. However, I know of no evidence to indicate that the leanest teams or dancers are the best. Moreover, even if this were the case, I invite coaches and dance instructors to renew the self-examination advocated earlier in this chapter. What are the true priorities of a high school coach or dance teacher?

## The Teacher as Adviser

### Detection and Referral of Eating Disorders

#### *Obstacles to Detection*

Eating disorders are difficult to detect for five reasons. First, educators are very busy people whose primary function is certainly not the detection of psychopathology. Second, many school employees, both female and male, do not see anything wrong with most of the attitudes and dieting practices that contribute to eating disorders. Third, in isolation many of the so-called "warning signs" of anorexia nervosa or bulimia—for example, unusual eating habits or oversensitivity to criticism—are (a) not abnormal according to the IMAD criteria (see Chapter 1) or (b) possibly indicative of other serious problems. Fourth, a significant number of adolescents with eating disorders are intelligent, compliant achievers who do not stand out among the problem students who often inhabit crowded classrooms. Finally, for various reasons—fear of enforced weight gain, interpersonal anxiety, guilt, the need to binge—most anorexics and bulimics are incredibly adept at hiding their eating disorders. It is not unusual for husbands to be unaware of chronic bulimia in their wives of 20 years (2).

### *General Principles of Identification*

Despite these difficulties, all members of the school staff are in an excellent position to detect eating disorders. In their varied roles, they come to know many students quite well.

Table 10—1 shows the warning signs of anorexia nervosa and bulimia. Five rules are important in applying this information (12, 17):

1. The purpose of detection is the identification of a problem and referral to the appropriate services—not accurate labeling. The function of school employees is to weld intuition, knowledge, and concern into support for those who need professional and specialized help, not to act as trained diagnosticians.
2. Use more than hearsay or direct observations of behavior (such as walking in on a student who is inducing vomiting after lunch) before making a judgment about a student. For example, speak confidentially to the student.
3. Eating disorders are syndromes composed of a number of interrelated problems, some of which are found in other psychological disorders. In accordance with the IMAD criteria and the warning signs listed in Table 10-1, your conversation with a student about whom you are worried should elicit both general and specific information. The general category includes physical appearance, functioning at school and at home, feelings about the self and others, and relationships with others. The specific category encompasses eating habits, exercise patterns, preoccupation with weight and dieting, and use of dangerous weight control methods such as self-induced vomiting, diet pills, and laxatives.

   There is no script for obtaining this information because a teacher's detection of a possible eating disorder should unfold within a compassionate and forthright conversation, not a diag-

## Table 10–1. The Warning Signs of Anorexia Nervosa and Bulimia

### SIGNS OF ANOREXIA NERVOSA OR BULIMIA

*Food and Weight Control*

Preoccupation with weight, food, calories, and dieting
Claims of "feeling fat" when weight is normal or low
Guilt and shame about eating
Frequent weighing
Evidence of binge-eating
Hoarding food
Use of laxatives, diuretics, purgatives, and emetics
Use of diet pills
Secretive vomiting: leaving for the bathroom immediately after a meal

*Personality and Emotionality*

Moodiness and irritability
Inflexibility and resistance to changes in routine
Low self-esteem
Perfectionism and dichotomous thinking ("I'm thin" or "I'm gross")
Chronic dissatisfaction with grades and with self, regardless of level of performance
Social withdrawal and intolerance of others
Oversensitivity to criticism
Extreme concern about appearances, both physical and behaviorial

### SIGNS OF ANOREXIA NERVOSA

Significant weight loss in the absence of related illness
Extremely thin appearance
Signs of starvation: a thinning of hair; hair loss; the appearance of fine, raised white hair (lanugo) on the checks, neck, forearms, and thighs; repeated gastrointestinal problems; yellowish appearance of the palms or soles of the feet
Significant reduction in eating coupled with a denial of hunger
Dieting with relish when not overweight
Amenorrhea in women
Unusual eating habits: preference for foods of a certain texture or color, compulsively arranging food, unusual mixtures of food

*Sources:* Bayer and Baker (1), Garfinkel and Garner (3), *NAAS Newsletter* (July-September), Neuman and Halvorson (10), Pope and Hudson (13), Pratt (14), Rubel (15), Sansone (16).

Table 10-1—*Continued*

Obsessive and prolonged exercising despite weakness, fatigue, illness
Complaints of feeling bloated or nauseated after eating a small or normal amount

SIGNS OF BULIMIA

Evidence of binge-eating: actual observation, verbal reports, large amounts of food missing, stealing money or food
Habitual overeating in response to stress
Frequent weight fluctuations of 10 pounds or more
Eating (not sampling) foods such as dough, canned frostings, or maple syrup without preparing them
Evidence of purging via vomiting, laxative/diuretic use, emetics (e.g., syrup of ipecac), frequent fasting, excessive exercising
Swelling of the glands under the jaw (caused by frequent vomiting), yielding a "chipmunk" appearance
Frequent and unusual dental problems

nostic interview (see item 1 above). The four important principles here are as follows:

a. The warning signs listed in Table 10-1 should serve as guides to communication with a student suspected of disordered eating. They are not intended to be a diagnostic checklist or an interview protocol (see item 1 above).

b. This means that teachers, as well as staff and concerned students, should not leap to conclusions on the basis of one sign (for example, weight loss) or on the basis of the student's proclamation that he or she has an eating disorder.

c. The more comprehensive the conversation with regard to the quality of the student's life and the role of food, weight, and eating within that life, the more effective the detection and referral process (see item 2 above).

d. To avoid overdiagnosis of eating disorders and misdiagnosis of other significant problems (for example, depression), the presence of an eating disorder must be verified by an expert clinician.

4. Consult with at least one other teacher, the school counselor, *and* the school psychologist before reaching a decision about referral.
5. Throughout the process of detection, referral, and recovery, keep the focus on feeling healthy and functioning effectively, not on weight lost or gained.

### *General Principles of Referral*

The effective treatment of eating disorders requires a professional therapist with special training and considerable skill. Thus, such treatment is not the province of teachers, school counselors, or even school psychologists. What follows are some general principles for helping students with eating disorders and their families to find the right person or organization in your community or neighboring area. These suggestions are based on a precious few readings (1, 10, 12, 14, 17, 18); my interpretation of conversations with experts from the National Anorexic Aid Society (see Appendix I); and my four years of experience educating and advising (not counseling) teachers and students from middle school through college about eating disorders (6), suicide (7), and domestic violence. In other words, this section is written in part from experience as a *teacher* of psychology, not as a psychologist.

*Be informed about the referral process in your school system.* Ask your school administrators, school nurses, and counselors/psychologists for specific information about the steps involved in verifying the presence of an eating disorder and arranging for proper services.

*Be informed about the services in your community and surrounding areas.* This will increase

students' perception of both your authoritativeness and your degree of concern for them. Moreover, presenting *options* decreases everyone's helplessness by emphasizing hope and choice. Lists of services pertaining to eating disorders may be obtained from an eating disorders association (see Appendix I), a nearby hospital, a mental health association, and the reference expert at the public library.

*Be compassionate and forthright.* Tell the student directly that you are concerned about him or her. Present the specific reasons for your concern, emphasizing health, apparent unhappiness, conflicts at school, unexpectedly low academic performance, and obvious evidence of bingeing and purging. Telling the student that he or she is "too thin" or "too committed to dieting" is of little or no value, and, indeed, may be taken as a compliment. Similarly, use of the labels "anorexia nervosa" and "bulimia" is often counterproductive; once again, the issue for teachers is not diagnosis, but concern for someone who meets the criteria of inefficiency, misery, alienation, and disturbance (see Chapter 1). Convey your desire to get involved in the process of helping by expressing a willingness (not a need) to provide literature, to obtain information about services, to talk with the student further, or to accompany the student to see the school counselor or psychologist. Table 10–2 lists several publications that should meet the needs of most teenagers for straightforward, informative, and readable material (see also Appendix II).

The principles of empathy and honesty should also be applied in conversations with students who are concerned about a friend whom they suspect of having an eating disorder. Their genuine concern is often mixed with confusion about the symptoms and the judgment of abnormality, and with fear of repercussions from "turning someone in." In talking with these responsible students, keep in mind how an adult feels when a colleague seems to be drinking too much.

## Table 10–2. Selected Publications on Eating Disorders for Teenagers

*About Anorexia Nervosa* (#1452) and *About Bulimia* (#1453)

These "scriptographic" pamphlets are designed to convey a large amount of information in a brief, simple, and straightforward fashion. They are in widespread use in mental health associations, libraries, hospitals, and high schools. Information about individual or bulk purchases is available from the Channing L. Bete Company, Inc., 200 State Road, South Deerfield, MA 03173.

*Anorexia Nervosa and Bulimia: Two Severe Eating Disorders* by Beverly Jacobson

Although it is also designed for the lay reader, this public affairs pamphlet (#632) provides more detailed and better organized information than the scriptographic pamphlets. Information about individual or bulk purchases is available from Public Affairs Pamphlets, 381 Park Avenue South, New York, NY 10016.

*Anorexia Nervosa and Bulimia* by J. Bradley Rubel

This 11-page pamphlet addresses the subject of eating disorders by posing a number of basic questions and answering them in straightforward language. For example, What is anorexia nervosa? What is bulimia? Why should I know about anorexia nervosa and bulimia? How does anorexia nervosa (bulimia) begin? What are the symptoms of anorexia nervosa (bulimia)? Can anorexia nervosa and bulimia be treated successfully? But aren't anorexics and bulimics happy?—After all, they are controlling their weight. This pamphlet can be obtained from Anorexia Nervosa and Related Eating Disorders Inc., (ANRED), P.O. Box 5102, Eugene, OR 97405 (503–344–1144).

*The Best Little Girl in the World* by Steven Levenkron (Chicago: Contemporary Books, 1978 or New York: Warner Books, 1981)

Steven Levenkron, an internationally known expert on the treatment of eating disorders, is the author of this novel about a teenage girl's descent into anorexia nervosa and her successful participation in a hospital-based program of weight restoration and nurturant-authoritative psychotherapy.

*Note:* It is imperative that teachers read any pamphlet or book before recommending it to teenagers.

Table 10–2—*Continued*

*When Will We Laugh Again? Living and Dealing with Anorexia Nervosa and Bulimia* by Barbara P. Kinoy and others (New York: Columbia University Press, 1984)

This 135-page book is a sensitive and skillful blend of up-to-date facts about eating disorders and numerous personal statements by anorexics, bulimics, and their families. Information about purchase is available from the American Anorexia/Bulimia Association, 133 Cedar Lane, Teaneck, NJ 07666.

Unless the situation is an emergency, concerned friends should be encouraged to make the choice themselves. Teachers can facilitate responsible decision making by confirming the seriousness of the matter, acknowledging the ability of adolescents to make mature choices, being aware of options, and helping to formulate the ethical question: Is "a live, angry friend . . . better than a severely ill or dead one?" (10, p. 223). It is likely that the affected student will be angry, but it is also very probable that the friendship will weather the storm. As is the case for the adult whose colleague is a problem-drinker, it is very difficult for students to decide to intervene in a peer's life. Consequently, as an adviser, the teacher should be patient and remain available for consultation and support.

*Be patient.* Be prepared for the possibility that students with eating disorders and their friends will need time and further opportunities for discussion before accepting your concern and taking your advice. Even if you are certain that the anorexic or bulimic student is wrong in protesting that "everything is really OK," it is very important to respect the adolescent's struggle for autonomy. Unless the student is suicidal or completely out of control, accept his or her need to think it over. Make sure, however, to leave the student with the impression that (a) you feel strongly that something is the matter, (b) you are more than willing to speak further with him or her about the matter, and (c) you care enough to check back soon with the student on how things are going.

*Know what to do in an emergency.* Ask school administrators, school nurses, and counseling personnel to help you prepare *in advance* for the possibility that a student you reach out to will be suicidal, light-headed from starvation, or bingeing and purging out of control. As a general rule, if the student has a specific plan for self-destruction with a lethal and available method, treat this communication of despair as a medical emergency analogous to a severe blow on the head: do not leave the person alone and send someone for help.

*Know your limits.* Do not become overinvolved in trying to help a student with an eating disorder. Overinvolvement by school staff is an honest reaction to concern and confusion, but it is no substitute for professional care. Moreover, "getting in over your head" usually converts an initial willingness to "do anything" for that student into anger, despair, or dissociation, all of which only hurt the student in the long run. Do not promise to be available "any time" for consultation unless you really mean it, unless you are honestly prepared for contacts late at night or on weekends. If the student requires your continual support in a way that begins to encroach on your life, however, the problem is too big for you to handle. Your irritation in this regard is a signal that it is time to seek assistance from administrators and counselors. Do not fall into the trap of promising the student you will keep the problem a secret; this may be a promise that your responsibility to a young life prevents you from keeping.

### *Advising the School System*

*The Fall In-Service Meeting.* Eating disorders and unhealthy weight management practices are significant health problems for many teenagers. Thus, it would be reasonable for a teacher or, better yet, a group of teachers, counselors, and nurses to request that the back-to-school in-service meeting address these issues. If the school system is prepared to make a major commitment to educating

staff, an entire morning could be devoted to a program provided by an eating disorders association. If there is time for only a short presentation, a local expert could be invited to speak on the most relevant topic for the group—for example, "Definitions, Detection, and Referral." For more information about the best way to educate the staff of a school system, contact one or more of the eating disorders associations listed in Appendix I.

*School Counselors and School Nurses.* It is very important for teachers interested in the prevention of eating disorders to coordinate their efforts with those of school counselors, school nurses, and psychologists. Before discussing the matter with them, encourage these professionals to read a chapter called "Junior High and High School" (14) in Neuman and Halvorson's *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists* (10). Written by Janet M. Pratt, a counselor for junior and senior high school students in Fargo, South Dakota, this chapter will provide school counselors and school nurses with a number of practical suggestions for detection and referral, working with teachers, educating and advising parents, and promoting adolescent development.

*The School Librarian/Media Center Director.* The prevention of eating disorders requires the availability of appropriate literature for students, teachers, counselors, nurses, and parents. Teachers are strongly encouraged to work closely with the school librarian/media center director, the school nurse, and an eating disorders association to select, organize, and update the books and articles on eating disorders and related topics (for example, fashion and health) that are most appropriate for different developmental levels (11, 14; and see Appendix II). Once the materials for students are in place, the librarian/media center director should find a way to keep confidential the names of those who check them out. (14).

*The School Newspaper.* Many students, teachers, and parents read the school newspa-

per. Teachers could encourage the faculty adviser and the student editors to develop a series of articles concerning eating disorders and their relationship to fashion, diet, self-esteem, relationships, and so forth.

## The Teacher in the Community

Any school employee who is very committed to the prevention of eating disorders may wish to become involved in educating the public about anorexia nervosa, bulimia, and the role of the school system in prevention. There are many ways in which educated lay people can contribute to public education (8). Two of the foremost are public speaking and use of the media.

### *Public Speaking*

Teachers are in an excellent position to combine their communication skills, knowledge of eating disorders, and position of respect in the community into clear and effective presentations to civic groups, child conservation leagues, mental health associations, adult education classes, fraternal groups, and adult sororities. One need not be an expert clinician to provide people with good basic information about the nature of eating disorders, warning signs, resources for treatment, sociocultural factors, and the role of public education. In fact, most of these groups are constantly searching for local speakers with topics of current interest.

### *The Media*

*Newspapers*. Particularly in smaller towns, where the number of staff for the writing of feature stories is low and the interest in local accomplishments is high, the newspaper may be delighted to publish an article by a teacher on eating

disorders. Teachers of speech, health, home economics, or English could work with students in the class to write such an article and then submit it to the paper under joint authorship.

*Distribution of Literature.* Teachers who do not have the inclination or time to write about eating disorders may choose to obtain pamphlets about anorexia nervosa and bulimia from an eating disorders association. These can be distributed to any number of organizations that consent to display them—for example, public libraries, churches and temples, doctors' and dentists' offices (severe dental problems can result from bulimia), and supermarket bulletin boards. If the association has only a limited number of free pamphlets, the committed school employees should consult the local or national mental health association, or a nearby hospital, about the possibility of securing funds for the purchase of sufficient numbers.

*Radio.* Most radio stations have at least one community affairs program. There is no reason why a teacher would not be welcome on this type of show to discuss adolescent development, eating disorders, and the school system.

## Conclusions and Implications

### Primary Prevention

*Conclusions.* The primary prevention of eating disorders requires the elimination of factors that place adolescents at risk for developing anorexia nervosa and bulimia. As discussed in Chapters 7 through 9, these factors include the worship of thinness, ignorance about normal weight regulation and nutrition, low self-esteem, sexism, negative coping skills, and fanaticism, to name but a few. Such problems reflect sociocultural influences to some extent, and school is a very important part of social

experience during the adolescent years. Thus, teachers, working within a supportive school system, are in an excellent position to help psychologists and psychiatrists combat ignorance, promote healthy development, and otherwise transform "sociocultural influences" from a risk factor into a preventive force. The focus of educational efforts could be any or all of the following: students, faculty, counselors, nurses, librarians/media center directors, and any other members of the school staff, parents, or the general public.

*Implications.* Teachers who are concerned about the prevalence of eating disorders and dysfunctional eating habits should incorporate material on these topics into their lesson plans. These lessons will be most effective if they are coordinated with the education of school personnel and other people dedicated to the development of healthy students. Although there is no scientific evidence available on the subject, experts are agreed that caring, well-informed, and sensitive teachers can make a difference. One need not be an expert to start people thinking and talking about something important.

## Secondary Prevention

*Conclusions.* Secondary prevention requires an awareness by school employees and students of the warning signs of an eating disorder, the resources for professional therapy, and the basic skills involved in helping anorexics and bulimics receive effective treatment. With eating disorders in particular, an illness of short duration is a very strong predictor of success in treatment. Given the amount of time adolescents spend away from home, and given the distinct possibility of pronounced conflict within the families of anorexics and bulimics, peers and teachers are often in a better position than the family to observe, acknowledge, and act upon the early signs of anorexia nervosa or bulimia.

*Implications.* Teachers who are concerned about the destructiveness of eating disorders should educate themselves and their students about identification and referral, understanding and support, the ethics of helping someone who may initially be resistant, and the distinction between effective helping and irresponsible overinvolvement.

## Careful Planning

*Conclusions.* Topics such as body image, dieting, sex-role stereotypes, self-esteem, and psychotherapy are sensitive ones for most teenagers (and teachers). Consequently, teachers should plan both their lessons on eating disorders and their advising function very carefully, using these guidelines:

1. Examine honestly your attitudes about these topics.
2. Educate yourself about eating disorders, relevant literature for teenagers, resources for facilitating classroom discussion, and community services for the treatment of anorexia nervosa and bulimia. Contacting an eating disorders association is a very good way to begin this process.
3. Coordinate your efforts with those of the school counselor, the school psychologist, the school nurse, the school librarian/media center director, and other staff. Most people—anorexics, bulimics, psychologists, teachers—feel better and work more productively when they are part of a meaningful network.
4. Work to develop an atmosphere of respect for self and others in the classroom. Demonstrate by your own actions what it means to be compassionate, forthright, and patient in discussing a sensitive subject.
5. Know your limits: you are a teacher or other school employee and an adviser, not a therapist or diagnostician.

*Implications*. This book should not be seen as the only resource necessary for the effective discussion of eating disorders with students in the classroom and with those seeking advice about anorexia nervosa and bulimia. Rather, it should be but one aspect of a collaboration among the teacher, the librarian/media center director, the counseling staff, the school nurse, and an eating disorders association. Prevention in this area is far too new for any one book or person to delimit it yet. Thus, by virtue of their skills and their immersion in the lives of adolescents, school staff are in a position to shape the prevention of eating disorders in creative, exciting, and productive ways.

## References

1. Bayer, A. E., and Baker, D. H. *Not Just a Skinny Kid: The Anorexic or Bulimic Teenager*. Boys Town, Nebr.: Father Flanagan's Boys' Home in cooperation with the National Mental Health Association, 1984. Pamphlet available from Communications and Public Service Division, Father Flanagan's Boys' Home, Boys Town, NE 68010.
2. Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion*. New York: Doubleday, 1983.
3. Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.
4. Garner, D. M., and Garfinkel, P. E. "Introduction." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 3–6. New York: Guilford Press, 1985.
5. Gottesfeld, J. *Abnormal Psychology: A Community Mental Health Perspective*. Chicago: SRA, 1979.
6. Levine, M. P. *The Psychology of Eating Disorders: A Lesson Plan for Grades 7–12*. Edited by A. B. Enright, N. Kayne, and C. Tootell. Columbus, Ohio: National Anorexic Aid Society (NAAS), 1983. Available from NAAS, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).
7. _____. "Protocol for the Discussion of Adolescent Suicide in High School Classrooms." Unpublished manuscript,

1984. Available from Michael Levine, Psychology Department, Kenyon College, Gambier, OH 43022.

8. _____. "Developing a Pilot Community Program for the Prevention of Eating Disorders." Workshop presented at Third National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1984. Available from Michael Levine, Psychology Department, Kenyon College, Gambier, OH 43022.
9. National Anorexic Aid Society (NAAS). "Warning Signs of Anorexia and Bulimia." *NAAS Newsletter* 9, no. 8 (October–December 1985). Available from National Anorexic Aid Society, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).
10. Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*. New York: Van Nostrand Reinhold, 1983.
11. Oldis, K. O. "Anorexia Nervosa: The More It Grows, the More It Starves" (Young Adult Literature). *English Journal* (January 1986): 84–87.
12. Peters, C. "Anorexia Nervosa and Bulimia: Focus on Schools." *NAAS Newsletter* 7 (April–June 1984): 1–2. Available from National Anorexic Aid Society, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).
13. Pope, H. G., Jr., and Hudson, J. I. *New Hope for Binge Eaters: Advances in the Understanding and Treatment of Bulimia*. New York: Harper and Row, 1984.
14. Pratt, J. M. "Junior High and High School." In *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*, by P. A. Neuman and P. A. Halvorson, pp. 165–85. New York: Van Nostrand Reinhold, 1983.
15. Rubel, J. B. *Anorexia Nervosa and Bulimia*. Eugene, Ore.: Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED). Pamphlet available from ANRED, P.O. Box 5102, Eugene, OR 97405 (503–344–1144).
16. Sansone, R. "Overview of Medical Complications in the Treatment of Eating Disorders." Paper presented at Fourth National Conference on Eating Disorders of National Anorexic Aid Society, Columbus, Ohio, October 1985.
17. Tootell, C. "Survival Suggestions for Schools." *NAAS Newsletter* 7, no. 3 (April–June 1984). Available from National Anorexic Aid Society, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).
18. _____. "Survival Suggestions: How to Help." *NAAS Newsletter* 8, no. 3 (October–December 1984). Available from National Anorexic Aid Society, 5796 Karl Road, Columbus, OH 43229 (614–436–1112).

19. Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.

20. Wooley, S. C., and Wooley, O. W. "Intensive Outpatient and Residential Treatment for Bulimia." In *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 391–430. New York: Guilford Press, 1985.

# Appendices

APPENDIX I

# Eating Disorders Organizations

Anyone seriously interested in finding out more about eating disorders for purposes of classroom instruction, student advising and counseling, staff development, or public education should contact the national eating disorders associations plus a regional organization or a hospital-based clinic. For example, the list of readings in Appendix II is based in large part on recommendations published by the four national eating disorders associations, as are some of the specific suggestions for teachers that comprise Chapter 10.

## National Organizations

### Names and Contact Information

American Anorexia/Bulimia Association, Inc.
(AA/BA)
(founded 1978)
133 Cedar Lane
Teaneck, NJ 07666
201-836-1800

Anorexia Nervosa and Related Eating Disorders, Inc.
(ANRED)
(founded 1979)
P.O. Box 5102
Eugene, OR 97405
503-344-1144

National Anorexic Aid Society, Inc. (NAAS)
(founded 1977)
5796 Karl Road
Columbus, OH 43229
614-436-1112

National Association of Anorexia Nervosa and Associated Disorders (ANAD)
(founded 1976)
Box 271
Highland Park, IL 60035
312-831-3438

## General Description of Services

According to Amy Baker Enright, Executive Director of the National Anorexic Aid Society (see listing above) and the Center for the Treatment of Eating Disorders in Columbus, Ohio:

> These four national organizations are very similar in origin, mission, [and] the nature of the services they provide. . . . All four organizations were founded by women. Two of the founders are parents of daughters who suffered from an eating disorder, and the other two had themselves recovered from an eating disorder. These organizations were created to provide information and support to family members and to persons with anorexia nervosa and bulimia. Each organization provides a national telephone hotline; printed information on eating disorders; periodic newsletters; referral resources for professional treatment and self-help/support groups; workshops, seminars, and conferences for the lay and professional communities; and consultation to parents, professionals, and the media. (Enright, Butterfield, and Berkowitz, p. 498)

I strongly encourage people seeking more information to contact *all* the national associations. The services of each one are slightly different, and together their newsletters and publications provide an extraordinarily rich source of new reference works, personal statements by anorexics, bulimics, and their families, research updates, tips on advising and counseling, and forthcoming workshops. Moreover, I have found that all the organizations are friendly, responsive, and *extremely interested in preventive education.*

## Regional Organizations and Eating Disorders Clinics

Teachers, counselors, and parents can also obtain useful information from regional eating disorders organizations that are no less dedicated than the national associations. Examples include the Pittsburgh Educational Network for Eating Disorders, Inc., and the Center for the Study of Anorexia and Bulimia in New York. The composition, mission, and location of these regional groups are subject to change so it is a good idea to contact both the national eating disorders associations and nearby hospitals, mental health associations, or mental health centers to obtain information concerning the most effective regional organization in your area.

Eating disorders clinics are, of course, designed primarily to provide specialized treatment services for anorexics, bulimics, and their families. As a rule, however, they are also committed to primary and secondary prevention (see Chapter 10). Consequently, teachers should not hesitate to contact such clinics about educational materials, guest speakers, and tips on advising and counseling (Neuman and Halvorson). The addresses of the nearest clinics can be obtained from the national and state organizations.

### References

Enright, A. B.; Butterfield, P.; and Berkowitz, B. "Self-Help and Support Groups in the Management of Eating Disorders." In *Handbook of Psychotherapy for Anorexia and Bulimia*, edited by D. M. Garner and P. E. Garfinkel, pp. 491–512. New York: Guilford Press, 1985.

Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*. New York: Van Nostrand Reinhold, 1983. (See especially Chapter 9, "Additional Sources of Information and Support," pp. 203–11.)

APPENDIX II

# Suggested Readings and Films

Although the literature on eating disorders is rapidly expanding, there are many excellent books available that have stood the test of fast-paced developments in the understanding of anorexia nervosa and bulimia. The lists that follow are not comprehensive, because my intent is primarily to help readers begin the process of tracking down literature that will be most useful to them. Unless otherwise denoted, it should be assumed that the books or pamphlets listed are intended for teachers and parents, not students.

Here are some guidelines for making effective use of the suggested readings:

1. With one exception, do not recommend a book to a parent or student without having read it. The exception is *The Golden Cage* by Hilda Bruch (Cambridge: Harvard University Press, 1978).
2. For specific suggestions about literature appropriate for teenagers and young adults, consult an eating disorders association and the following article: Oldis, K. O. "Anorexia Nervosa: The More It Grows, the More It Starves" (Young Adult Literature). *English Journal* (January 1986): 84–87.
3. Work with your school and/or public librarian to identify new books and to obtain reviews of both newer and older literature. Note that the newsletters published by the National Anorexic Aid Society and the American Anorexia/Bulimia Association (see Appendix I) contain lists of new books and book reviews.

4. If you are interested in an advanced book, begin with *Anorexia Nervosa: A Multidimensional Perspective*, by P. E. Garfinkel and D. M. Garner (New York: Brunner/Mazel, 1982).

## General Information

### Introductory

Abraham, S. F., and Llewellyn-Jones, D. *Eating Disorders: The Facts*. New York-Oxford: Oxford University Press, 1984.

Boskind-White, M., and White, W. C., Jr. *Bulimarexia: The Binge/Purge Cycle*. New York: W. W. Norton, 1983.

Bruch, H. *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge: Harvard University Press, 1978. (Appropriate for teenagers)

Cauwels, J. M. *Bulimia: The Binge-Purge Compulsion*. New York: Doubleday, 1983.

Chenin, K. *The Obsession: Reflections on the Tyranny of Slenderness*. New York: Harper and Row, 1982.

Claypool, J., and Nelsen, C. D. *Food Trips and Traps: Coping with Eating Disorders*. New York: Franklin Watts, 1983. (Appropriate for teenagers)

Crisp, A. H. *Anorexia Nervosa: Let Me Be*. Orlando, Fla.: Grune and Stratton, 1980.

Dally, P., and Gomez, J. *Obesity and Anorexia Nervosa: A Question of Shape*. Boston: Faber and Faber, 1980.

Kinoy, B. P., and others. *When Will We Laugh Again? Living and Dealing with Anorexia Nervosa and Bulimia*. New York: Columbia University Press, 1984.

Landau, E. *Why Are They Starving Themselves?* New York: Messner, 1983. (Appropriate for teenagers)

Levenkron, S. *Treating and Overcoming Anorexia Nervosa*. New York: Charles Scribner's Sons, 1982.

Melville, J. *The ABC of Eating: Coping with Anorexia, Bulimia and Compulsive Eating*. London: Sheldon Press, 1983.

Neuman, P. A., and Halvorson, P. A. *Anorexia Nervosa and Bulimia: A Handbook for Counselors and Therapists*. New York: Van Nostrand Reinhold, 1983.

Palmer, R. E. *Anorexia Nervosa: A Guide for Sufferers and Their Families*. New York: Penguin, 1980.

Pope, H. G., Jr., and Hudson, J. I. *New Hope for Binge Eaters:*

*Advances in the Understanding and Treatment of Bulimia*. New York: Harper and Row, 1984.

Squire, S. *The Slender Balance*. New York: Putnam, 1983.

Vincent, L. M. *Competing with the Sylph: Dancers and the Pursuit of Ideal Body Form*. New York: Andrews and McMeel, 1980.

## Advanced

Andersen, A. E. *Practical Comprehensive Treatment of Anorexia Nervosa and Bulimia*. Baltimore: Johns Hopkins University Press, 1985.

Bruch, H. *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*. New York: Basic Books, 1973.

Emmett, S. W., ed. *Theory and Treatment of Anorexia Nervosa and Bulimia: Biomedical, Sociocultural, and Psychological Perspectives*. New York: Brunner/Mazel, 1985.

Fairburn, C. G. *Binge-Eating and Bulimia Nervosa*. London: Smith, Kline and French, 1982.

Garfinkel, P. E., and Garner, D. M. *Anorexia Nervosa: A Multidimensional Perspective*. New York: Brunner/Mazel, 1982.

Orbach, S. *Hunger Strike: The Anorectic's Struggle as a Metaphor for Our Age*. New York: W. W. Norton, 1986.

Palazzoli, M. S. *Self-Starvation: From Individual to Family Therapy in the Treatment of Anorexia Nervosa*. Translated by Arnold Pomerans. New York: Jason Aronson, 1978.

Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment*. New York: Walter de Gruyter, 1984.

# Fiction and Autobiography Appropriate for Teenagers and Young Adults

Katherine Oldis, M.Ed., teaches at Foxcroft Academy in Dover-Foxcroft, Maine. She has an anorexic daughter. The following books are the better ones that she has read and reviewed to meet the needs of students who ask her for fiction and autobiographies about eating disorders (see References [Oldis, 1986] for the reviews):

## Fiction

Aydt, D. *Katie*. New York: Scholastic, 1980.

Dean, K. S. *Maggie Adams, Dancer*. New York: Avon, 1980.

Hautzig, D. *Second Star to the Right*. New York: Avon, 1981.

Josephs, R. *Early Disorders*. New York: Farrar, 1980. (More mature teens)

Levenkron, S. *The Best Little Girl in the World*. New York: Warner, 1978. (See also the sequel: *Kessa*. New York: Popular Library/Warner, 1986.)

Ruckman, I. *The Hunger Scream*. New York: Walker, 1983.

Snyder, A. *Goodbye, Paper Doll*. New York: Signet, 1980. (More mature teens)

## Autobiography

Liu, A. *Solitaire: A Narrative*. New York: Harper and Row, 1979.

MacLeod, S. *The Art of Starvation: A Story of Anorexia and Survival*. New York: Schocken, 1982.

O'Neill, C. B. *Starving for Attention*. New York: Dell, 1982.

# Pamphlets on Eating Disorders

*About Anorexia Nervosa* (#1452) AND *About Bulimia* (#1453)
Scriptographic pamphlets available from
Channing L. Bete Company, Inc.
200 State Road
South Deerfield, MA 03173

*Anorexia Nervosa and Bulimia* by J. Bradley Rubel
Available from
Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED)
P. O. Box 5102
Eugene, OR 97405 (503-344-1144)

*Anorexia Nervosa and Bulimia: Two Severe Eating Disorders* by Beverly Jacobson
Public Affairs Pamphlet #632 available from
Public Affairs Pamphlets
381 Park Avenue South
New York, NY 10016

*Not Just a Skinny Kid: The Anorexic or Bulimic Teenager* by Alan E. Bayer and Daniel H. Baker
Available from
Communications and Public Service Division
Father Flanagan's Boys' Home
Boys Town, NE 68010

The November 1985–February 1986 issue of the newsletter of the American Anorexia/Bulimia Association, Inc. (see Appendix I), notes that the following pamphlets are available from Hazelden Educational Materials, Pleasant Valley Road, Box 176, Center City, MN 55012 (800–328–9000 or 612–257–4010 in Minnesota, Alaska, or outside the United States):

*Learn About Eating Disorders*
*Bulimia: The Binge-Eating and Purging Syndrome*
*Recovering* (The Story of an Overeater)
*Relapse for Eating Disorder Sufferers*
*Killing Ourselves with Kindness*
*Accepting Powerlessness*

## Films

*Bulimia: The Binge-Purge Obsession* (color, 20 minutes)
Rental and purchase information available from
Carle Medical Communications
510 West Main Street
Urbana, IL 61801 (217–384–4838)

*Dieting—The Danger Point* (color, 20 minutes)
Rental and purchase information available from
CRM/McGraw-Hill Films
100 Fifteenth Street
Del Mar, CA 92014 (619–453–5000)

*The Hunger Artist: A Portrait of Anorexia Nervosa* (30 minutes)
Rental and purchase information available from
Fat Chance Films
390 Elizabeth Street
San Francisco, CA 94114 (415–821–6217)

*Killing Us Softly* (color, 30 minutes)
Film about the impact of the portrayal of women in advertising on women's body image. Rental and purchase information available from
Cambridge Documentary films
P.O. Box 385
Cambridge, MA 02139 (617–354–3677)

*The Waist Land: Eating Disorders* (23 minutes)
Rental and purchase information available from
Coronet/MTI Film and Video, Distributors of
Learning Corporation of American
108 Wilmot Road
Deerfield, IL 60015

IMPORTANT NOTE: *Never* show a film without previewing it first to determine both its suitability for your audience and its connection with your lesson(s).

## Books on Related Subjects

Bennett, W. G., and Gurin, J. *The Dieter's Dilemma: Eating Less and Weighing More.* New York: Basic Books, 1982.

Gilligan, C. *In a Different Voice: Psychological Theory and Women's Development.* Cambridge: Harvard University Press, 1982.

Kano, S. *Making Peace with Food: A Step-by-Step Guide to Freedom from Diet Weight Conflict.* Allston, Mass.: Amity Publishing, 1985.

Keys, A., and others. *The Biology of Human Starvation.* 2 vols. Minneapolis: University of Minnesota Press, 1950.

Millman, M. *Such a Pretty Face: Being Fat in America.* New York: W. W. Norton, 1980.

Orbach, S. *Fat Is a Feminist Issue II.* New York: Berkeley Books, 1982.

Polivy, J., and Herman, C. P. *Breaking the Diet Habit.* New York: Basic Books, 1983.

Powers, P. S. *Obesity: The Regulation of Weight.* Baltimore: Williams and Wilkins, 1980.

## Teaching About Emotional Subjects: Two Model Curriculum Guides

*Adolescent Suicide: A Prevention Approach.* Teacher's Curriculum and Guide, 1984. Available from
Help Hotline, Inc.
P.O. Box 46
Youngstown, OH 44501 (216–747–5111)

*Skills for Violence-Free Relationships: Curriculum for Young People, Ages 13–18.* Written by Barrie Levy, 1984. Available from
Southern California Coalition on Battered Women
P.O. Box 5036
Santa Monica, CA 90405 (213–392–9874)

## References

Kinoy, B. P., and others. *When Will We Laugh Again? Living and Dealing with Anorexia Nervosa and Bulimia.* New York: Columbia University Press, 1984. (See pp. 133–35.)

Oldis, K. O. "Anorexia Nervosa: The More It Grows, the More It Starves" (Young Adult Literature). *English Journal* (January 1986): 84–87.

Vandereycken, W., and Meermann, R. *Anorexia Nervosa: A Clinician's Guide to Treatment.* New York: Walter de Gruyter, 1984. (See in particular Appendix 10–7: Literature for "Laymen," pp. 233–34.)

*Note*: Suggested readings and films were also obtained from literature generously provided by four of the national eating disorders associations listed in Appendix I:

American Anorexia/Bulimia Association (AA/BA)
Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED)
National Anorexic Aid Society (NAAS)
National Association of Anorexia Nervosa and Associated Disorders (ANAD)

*Michael P. Levine*

nea PROFESSIONAL LIBRARY

Stock No. 3289-6

279